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ABSTRACT

This study examines the Ryan White CARE Act (RWCA), which was passed in part to improve access to care services for underserved populations with HIV or AIDS. A major intent of the legislation was to expand the capacity of local agencies to provide direct care and support to those with HIV/AIDS. This care and support included health education and HIV prevention information. The RWCA is especially relevant for Latino communities, many of which are urban. This study was funded by the Health Resources and Services Administration (HRSA) to study the effects of Title I of the RWCA on the ability of Latino community-based organizations (CBOs) to provide direct care and support services. The study, which was conducted in two metropolitan areas, gained information from agency questionnaires and from interviews with 21 staff members at 14 Latino CBOs and 6 other interviews with Title I administrators in these areas. These 14 agencies served over 126,555 clients, 6,215 of whom were living with HIV/AIDS. Of these CBOs, 29% had applied for and received RWCA Title I funds. The study found that both funded and nonfunded agencies needed to strengthen their infrastructure systems and to build overall capacity to survive and compete with larger organizations. The need for funding for board development, strategic planning, improving development of services and program evaluation, and for developing plans and strategies for diversifying funding sources were commonly expressed. Recommendations for CBO development using RWCA funds are presented. Four appendixes contain the survey questionnaires, interview protocols, and biographical sketches of members of the research team. (Contains 14 tables and 13 references.) (SLD)

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Findings from a Study of Two Cities

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Impact of Ryan White CARE Act Title I on Capacity Building in Latino Community-Based Organizations:

Findings from a Study of Two Cities

August 1995

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I. EXECUTIVE SUMMARY

This study examines the Ryan White CARE Act (RWCA) which was passed, among other reasons, to improve access to care services for underserved populations with HIV/AIDS. A major intent of the legislation is to enhance and expand the capacity of local agencies to provide direct care and support services to persons living with HIV/AIDS.

Because Latinos have been disproportionately affected by the HIV/AIDS epidemic, the RWCA is especially relevant to Latino communities. Compounding the HIV/AIDS crisis for Latinos is the fact that they are less likely to have health insurance and, due to language and cultural barriers, more likely to encounter difficulties accessing health care than the general population.

The National Commission on AIDS has noted that Latino community-based organizations (CBOs) have an important role to play in improving access to care for Latinos living with HIV/AIDS. To do so, however, they often require initial support and technical assistance. Many Latino CBOs are at a disadvantage for providing these services because they have not yet developed the capacity to provide the types of health care services funded under RWCA, while others lack the type of infrastructure needed to provide such services under federal support. Thus, assistance to Latino CBOs in capacity building and in providing infrastructure support is necessary in order to strengthen their ability to provide HIV/AIDS care and support services.

The 1992 Health Resources and Services Administration (HRSA) Workgroup on Health Care Access Issues for Hispanics recommended conducting research to evaluate the effect of recent efforts under RWCA Title I on the ability of Latino CBOs to provide direct care and support services. This study was funded by HRSA to develop and pilot-test a methodology for evaluating if and how RWCA Title I funds have helped develop, expand, and enhance HIV/AIDS services in Latino CBOs. Specifically, the study investigated the following questions: 1) What has been the role of Latino CBOs in the Title I Planning Council and funding process?; 2) How have Title I funds received by Latino CBOs assisted agencies in developing, expanding, or enhancing services for persons with HIV/AIDS?; and 3) What are the capacity building needs of Latino CBOs and how can RWCA Title I help agencies build such capacity?

Our study was conducted in two eligible metropolitan areas (EMAs). It gained information from agency survey questionnaires and from interviews with 21 staff at 14 Latino CBOs and from a total of six other interviews with the Planning Council Chair, Title I Administrator, and the HRSA Project Officer for each EMA. The 14 agencies represent 82 percent of all Latino CBOs in the two EMAs and in 1992 served over 126,555 clients, of whom 6,215 were living with HIV/AIDS.

Our findings indicate that beyond representation on the Planning Council, an atmosphere of openness and inclusiveness in the planning process is critical if Latino CBOs are to feel that they are full participants who can affect the decision-making process.

Of all existing Latino CBOs in the two EMAs, 29 percent received and applied for Title I funding. The amount of funding they received represented 12.3 percent and 3 percent of the total budgets for the two EMAs, respectively. Information obtained from interviews indicates that receipt of funding is critical for enhancing and expanding the capacity of Latino CBOs in providing HIV/AIDS services. Evidence of expanded capacity in funded agencies is reflected in the increases in HIV/AIDS care staff and in the types of HIV/AIDS care and support services provided. The majority (67.7 percent) of persons with HIV/AIDS served by Latino CBOs were primarily Spanish speaking -- a finding that emphasizes the need for the kind of linguistically and culturally appropriate services that Latino CBOs can provide. Staff from funded and non-funded agencies alike stressed the need to build capacity to provide HIV/AIDS services in more Latino CBOs.

The study found that both funded and non-funded agencies demonstrate a need for strengthening their infrastructure systems and for building overall capacity in their agencies in order to survive over time and compete with larger organizations. The need for funding to support board development, strategic planning, improving development of services and program evaluation, and for developing plans and strategies for diversifying funding sources were commonly expressed by agencies. Funding for such activities under Title I would better equip agencies to develop, expand, and enhance their capacity to provide HIV/AIDS services.

The recommendations stemming from our study are as follows:

Recommendation #1: HRSA develop incentives to reward EMAs for successful efforts that increase the representation of Latino CBOs on the Planning Council, in the planning process, and among applicants..

Recommendation #2: HRSA create active outreach efforts to engage non-medical agencies with existing HIV/AIDS education and outreach programs in the Planning Council and planning process and encourage them to submit proposals to develop and provide HIV/AIDS services.

Recommendation #3: HRSA develop ways to provide Planning Council Chairs, RWCA Directors, and Federal RWCA Project Officers with information about the service needs and capacity building needs of agencies in communities of color within their EMAs.

Recommendation #4: HRSA develop and communicate clear guidelines for HRSA Project Officers, Title I Administrators, and Planning Councils on the kinds of capacity building activities that can and should be funded under RWCA.

Recommendation #5: HRSA include the following in its list of fundable capacity building activities under RWCA: a) administrative costs; b) training for CBO staff on proposal writing and design, implementation and evaluation of HIV/AIDS service and support programs; and c) board training and development, especially in the integration of HIV/AIDS services in an agency's long-term strategic plan.

Recommendation # 6: HRSA continue to gather data on: a) the representation of ethnic minority CBOs on RWCA Planning Councils; b) the amount of funds received by CBOs in ethnic minority communities throughout all EMAs; and c) racial/ethnic profiles of clients served through RWCA. HRSA should use these data to determine how responsive EMAs are to the needs of ethnic minority communities and make these data available to all EMAs.

Recommendation #7: HRSA conduct a series of regional studies with representative samples of EMAs in each region across all titles of RWCA (Title I, Title II, Title III, and Title IV programs). These studies should further investigate the factors that impede or facilitate the participation of ethnic minority CBOs in the planning process and application process throughout all RWCA programs.

II. INTRODUCTION

A. Background

As previously stated in the Executive Report, the Ryan White CARE ACT (RWCA) program was designed, in part, to improve access to care services for underserved populations with HIV/AIDS. A major intent of the legislation is to enhance and expand the capacity of local agencies to provide direct care services to persons with HIV/AIDS.

Clearly the Act is important to Latinos, who represent only 10 percent of the nation's population but make up a full 17 percent of the nation's population diagnosed with AIDS (CDC, 1994). Furthermore, the annual AIDS rates for Latino men (145.9), women (32.2), and children (3.6) are significantly higher than those for non-Latino white men (57.3), women (5.0), and children (.4) (CDC, 1994). Making matters worse, Latinos are more likely than non-Latinos and whites or African Americans to lack access to health care (Ginzberg, 1991) and less likely to have private or publicly funded health insurance than non-Latino whites or African-Americans.

In 1987, nearly one third (30.1 percent) of Latinos compared to 20.4 percent of African-Americans and 12.6 percent of non-Latino whites lacked health insurance (Ginzberg, 1991). Contributing to the lower rates of insurance coverage among Latinos are below-average family incomes, employment in jobs that do not provide private health insurance, and residence in states with low Medicaid enrollments (Ginzberg, 1991).

In its *1992 Report on Communities of Color*, the National Commission on AIDS identified four critical barriers preventing Latinos with HIV/AIDS from obtaining needed services. These were 1) low rates of health insurance coverage; 2) linguistic and cultural barriers in accessing care in the health delivery system; 3) lagging knowledge and continued misconceptions about HIV/AIDS and its treatment; and 4) attitudes about HIV that may place Latinos at greater risk for infection and delay in seeking care (National Commission on AIDS, 1992). The Commission urged service program providers to address such issues as cultural competence, literacy appropriateness, and language barriers in order to effectively serve Latino clients with HIV/AIDS. Furthermore, the report urged that efforts to foster trust and positive relationships between health care providers and the Latino community be undertaken.

While non-Latino agencies have an important role to play in providing care to Latinos with HIV/AIDS, our report focuses on the role that Latino CBOs can play. Latino CBOs are uniquely qualified to effectively deliver HIV/AIDS-related care because they can provide culturally and linguistically appropriate services. At the same time, however, Latino CBOs that have not yet developed the capacity to provide the types of health care and support services funded under RWCA find themselves at a disadvantage. While some Latino agencies, for example, have a sound infrastructure in place, they may require assistance in developing HIV/AIDS expertise and in designing programs that deliver care (National Commission on AIDS, 1992). Others, without some initial support and technical assistance, lack the necessary infrastructure to compete for RWCA funding.

Both of these examples point to a need to provide Latino CBOs with technical assistance and opportunities to build capacity in the area of HIV/AIDS. Several studies have documented the need of Latino CBOs for technical assistance in order to enhance and expand their capacity to provide HIV/AIDS services (Amaro and Gornemann, 1992; COSSMHO, 1990; Latino Health Network, 1989; Singer, Castillo, Davison and Flores, 1990).

The National Commission on AIDS specifically highlighted this need in its 1992 report on *The Challenge of HIV/AIDS in Communities of Color*:

> The Hispanic/Latino community is still facing tremendous programmatic challenges in its response to the HIV epidemic. Hispanic/Latino organizations have had difficulties in accessing the financial resources needed to operate successful HIV/AIDS programs ... They lack experience in accessing current information about funding sources. Other organizations because of limited infrastructure, insufficient work force, and limited management expertise also lack the capacity to successfully respond to requests for proposals. Thus, even when organizations have received information about funding opportunities, they may also need technical assistance in order to submit a competitive proposal. (National Commission on AIDS, 1992, p. 44).

The need for capacity building was considered so critical that it was a major focus of recommendations by the HIV/AIDS Workgroup on Health Care Access Issues for Hispanics convened in 1992 by the Bureau of Health Resources Development within the Health Resources and Services Administration (HRSA, 1991). The Workgroup recommended studying how recent efforts to build and enhance capacity to provide services to persons with HIV/AIDS, especially RWCA Title I funds, had affected Latino community-based organizations (HRSA, 1991). The Workgroup urged HRSA to consider evaluation projects focusing on participation in planning councils/consortia.

The following were suggested as important questions needing research: 1) Does a more representative and open planning council process result in increased access to Ryan White services by diverse populations?; 2) Does involvement of Hispanic organizations on HIV planning councils result in a) allocations which target care to Hispanic communities?

and b) increased use of existing Hispanic medical, home care, housing, food, and other services?; and 3) Are planning councils which are representative of the Hispanic community they serve more effective in filling the existing gaps in HIV services in that Hispanic community? (HRSA, 1991, p. 18).

The study summarized in this report is a direct outgrowth of the recommendations of the HIV/AIDS Workgroup on Health Care Access Issues for Hispanics and provides some initial answers to the questions posed by that group. The study's goal was to develop and test a methodology for evaluating whether and how RWCA Title I funds have helped develop, expand, and enhance the HIV/AIDS service delivery capacity in CBOs serving Latino populations.

In piloting this methodology, we also hoped to gain insight into how communities have experienced the RWCA planning and application process. Our study focused on Boston and San Diego, two eligible metropolitan areas (EMAs) funded under Title I. The project was conducted by Boston University School of Public Health and the National Coalition of Hispanic Health and Human Services Organizations (COSSMHO) with input from a Technical Advisory Panel[1] and the HRSA Project Officer for the study.

Our report is organized in four sections: Introduction, Methods, Findings, and Recommendations. The remainder of the Introduction provides a background to the study that describes the epidemiology of HIV in Latino communities and includes a brief historical account of the role Latino CBOs have played in responding to the epidemic. In addition, we review key features of the RWCA Title I legislation.

B. Latinos and the HIV Epidemic

While representing only 10 percent of the U.S. population, Latinos account for over 17 percent of all reported AIDS cases. As of December, 1993, a total of 61,297 cases of AIDS was reported among Latinos, including 50,942 men, 9,066 women and 1,289 children (CDC, 1994).

Through 1993, the major routes of transmission among Latino men with AIDS were male-to-male sex (45 percent), injection drug use (38 percent), and male-to-male sex and injection drug use combined (seven percent) (CDC, 1994). Among Latinas, who accounted for 20 percent of women with AIDS, the major transmission routes were injection drug use (48 percent) and heterosexual contact with an infected person (42 percent) (CDC, 1994). Latino children accounted for 25 percent of all pediatric cases of AIDS, with in-utero exposure (91 percent) the primary route of transmission (CDC, 1994).

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[1] A group of four individuals familiar with issues of HIV/AIDS in the Latino community and with experience in the implementation of the Ryan White Care Act at the local and national levels comprised the Technical Advisory Group. (Juan Ledesma, Mara Patermaster, José Toro-Alfonso and Roberto Soliz). The Technical Advisory Panel provided input in the design of the study, the development of data collection tools and in the recommendations presented in this report.

There are major geographic differences in the epidemiology of HIV/AIDS among Latino groups that have critical implications for developing and implementing appropriate prevention and health service programs. In Puerto Rico and in the northeastern United States, particularly New York, New Jersey, and Massachusetts, injection drug use is the most commonly identified risk factor, accounting for 50 to 70 percent of Latino AIDS cases. In contrast, in Arizona, California, New Mexico, and Texas, more than 70 percent of all Latino AIDS cases occur among men who have sex with men (COSSMHO, 1991).

Place of birth also points to different patterns of Latino AIDS cases (Diaz, Buehler, Castro and Ward, 1993). Male-to-male sex is the predominant exposure category among Latino men with AIDS born in the continental U.S. (51 percent), Dominican Republic (42 percent), and Central America, South America, Cuba, and Mexico (65 percent) (Diaz et al., 1993). On the other hand, male-to-male sex is less often reported among men with AIDS born in Puerto Rico (22 percent), for whom injection drug use is the most common transmission route (61 percent) (Diaz et al, 1993). In comparison, injection drug use is lower among Latino men born in the continental U.S. (35 percent) or the Dominican Republic (27 percent) and among non-Hispanic white men (10 percent) (Diaz et al, 1993). Among Latina women, the routes of transmission also differ by place of birth. Injection drug use is the predominant exposure category among Latinas born in the U.S. (56 percent) and Puerto Rico (46 percent), but is less often reported among Latinas born in Central America, South America, Cuba, and Mexico (30 percent) (Diaz et al, 1993).

This brief epidemiological profile of AIDS cases demonstrates the diverse and complex nature of the epidemic among Latinos in the United States. Its geographic and population related patterns have implications for the planning and delivery of HIV/AIDS prevention and health care services.

C. The Role of Latino Community-Based Organizations (CBOs)

The onset of the HIV epidemic took place at a time when the public health system was particularly overburdened with demand and undermined by shrinking financial and human resources (National Commission on AIDS, 1992). Latino CBOS, like agencies in other communities, moved from a state of unawareness in the early years to active response and engagement in the fight against AIDS at the national and local levels. The role of CBOs in the Latino community's efforts to address the HIV/AIDS epidemic have been documented by the National Commission on AIDS (National Commission on AIDS, 1992; Rodriguez, Villa-Barton, Farugue, & Rodriguez, 1994; National Hispanic/Latino AIDS Coalition, 1993; Amaro and Gornemann, 1992; Northeast Hispanic AIDS Consortium, 1992; Latino Health Network, 1989; Singer, Castillo, Davison, & Flores, 1990).

At the local level, Latino AIDS organizations were established in the early and mid-1980's to address the Latino community's HIV prevention and service needs. Latino AIDS organizations and many Latino CBOs were involved in HIV/AIDS-related efforts before government funding became available to support prevention and care efforts among the ethnic communities (Amaro & Gornemann, 1992; Singer et al, 1990; Latino Health Network, 1980; COSSMHO, 1990).

The acute need for services at the local level, along with a call from the CDC for applications from national and regional coalitions on HIV/AIDS from communities hard hit by the epidemic, provided the impetus for the formation of three regional Latino HIV/AIDS coalitions. Established in 1988 to assess and coordinate efforts being implemented at the local level, these coalitions are the Northeast Hispanic AIDS Consortium, the Midwest Hispanic AIDS Coalition, and the Southwest Border Hispanic AIDS Coalition. In addition, since the mid-1980s, Latino organizations and university-based Latino researchers also have been active in assessing and addressing the impact of HIV on Latinos through symposia and conferences such as the 1988 Latino AIDS Symposium held in Los Angeles; the 1989 National Latino/Hispanic AIDS Teleconference; and the 1993 National Hispanic/Latino AIDS Agenda in Washington, D.C. (Singer et al, 1990; COSSMHO, 1991; National Hispanic/ Latino AIDS Coalition, 1993).

Through the efforts of local, regional, and national Latino organizations, a growing public awareness of the impact of HIV/AIDS in Latino communities has emerged. However, questions remain as to the success that Latino CBOs have had in accessing new resources for expanding HIV/AIDS direct care programs. Specifically, there remains interest in determining whether Latino CBOs have participated in the local planning process for direct service dollars stemming from the RWCA and learning whether the RWCA has improved the capacity of Latino CBOs to respond to the epidemic and to the health care needs of Latinos living with HIV/AIDS.

This study seeks to develop a methodology to assess the impact of RWCA on enhancing and expanding the capacity of Latino CBOs to provide direct care services to persons with HIV/AIDS. Prior to discussing the study's methods and findings, the following section reviews the RWCA and its intended purpose.

D. Ryan White CARE Act: Title I

The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act of 1990 was enacted by Congress specifically to provide services to people with HIV. The purpose of the Act is to "improve the quality and availability of care for individuals and families with HIV disease." Funds allocated under the CARE Act are administered by the Health Resources and Services Administration (HRSA).

The CARE Act is divided into four titles:

Title I provides direct assistance to eligible metropolitan areas (EMAs) with the largest number of reported AIDS cases;

Title II provides assistance to all states to improve the quality, availability, and organization of health care and support services to people with HIV and their families;

Title III provides assistance to community health centers and other non-profit entities to support early intervention services; and

Title IV supports the development of comprehensive service systems for children, adolescents, and families.

Under the RWCA Title I funds are awarded to the Chief Elected Official (CEO) of the city or urban county that administers the local public health department with the greatest number of people with AIDS in the EMA. The RWCA also requires that the CEO appoint a Planning Council responsible for:

- establishing priorities for allocating funds within the EMA;
- developing a comprehensive plan for the delivery of HIV care services that is compatible with existing state or local plans; and
- assessing the administrative efficiency of the funds allocation process.

The EMA may grant funds to public or private nonprofit agencies and organizations to provide the following services:

- outpatient and ambulatory services and health and support services, including case management and treatment services; and
- inpatient case management services that expedite the discharge process.

EMAs vary greatly in the activities that they fund in an effort to improve the quality and availability of care for persons with HIV. Some EMAs have directed substantial funds to infrastructure development in agencies in an effort to assist them in building capacity to provide HIV services. In contrast, other EMAs fund only direct health care and support services. The EMA's interpretation of allowable activities is critical to Latino CBOs because they often need infrastructure support and capacity building for direct health care and support services.

III. METHODS

This section describes the original study methods proposed, modifications made in the methods during field work, and all procedures and instruments employed in the study.

A. Description of Study Sites

The criteria for the selection of the two EMAs were 1) that they reflect the diversity of the Latino community in the U.S. as well as the varied dynamics of the epidemic among Latinos, and 2) that they were of a suitable size to facilitate the completion of the study within a relatively short period of time. For this reason, medium-sized rather than large EMAs (such as New York City or Los Angeles) were selected.

This section describes the epidemiology of AIDS cases in the two study sites during the study time frame and the planning process as presented by each EMA in the RWCA application to HRSA. In subsequent sections, the descriptions of the planning process provided in the application are compared to information obtained through the interviews conducted for this study.

HIV/AIDS Cases and the RWCA Planning Process in the San Diego EMA. According to its 1994 RWCA application, San Diego is a single county EMA with a population of 2.6 million. The nation's sixth and California's second most populated city, San Diego's population is ethnically diverse -- about 55 percent white, over 20 percent Latino, eight percent Asian or Pacific Islander, six percent African-American, and about one percent Native American. Located in southern California, it is the only EMA situated on an international border. Another 1.1 million people live in nearby Tijuana, Mexico's largest border city. The area acts as a bi-national economic system and is a heavily active bi-national border crossing.

As of January 31, 1994, 5,483 cases of AIDS were reported within the EMA, 43 percent of which were reported within the preceding 46 months. Cumulatively, 73 percent of the cases were reported among non-Latino whites, 15 percent among Latinos, 10 percent among Blacks, one percent among Asians and Pacific Islanders, and less than one percent among Native Americans. About 79 percent of the EMA's AIDS cases were reported among gay men, eight percent among IDU gay/bisexual men, and seven percent among IDUs. Five percent of all reported AIDS cases occurred among women and six percent among children.

San Diego statistics reflect an epidemic that differs from that reported among Latinos at the national level in that it has affected primarily gay men. Also unlike other areas in the country, Latinos in this EMA are under-represented among those diagnosed with AIDS. However, the application notes that under-reporting of Latino AIDS cases is suspected.

According to the San Diego application for RWCA, the RWCA Planning Council is comprised of 30 members. Of these, 47 percent are persons of color and 30 percent are consumer representatives living with HIV. To promote community involvement in the planning process, the Planning Council coordinates with the Title II HIV Care Coalition through a joint planning committee. The Planning Council begins the planning process with data gathered through an annual client and provider needs assessment and with community input. The survey instruments are sent to the funded agencies and to providers and are returned for analysis to the San Diego County AIDS Coordination Office in the Department of Health Services. General community meetings are held in various areas of the county to gather direct input. Newspaper advertisements, flyers placed in key locations, and notices mailed to a list of about 1,000 inform interested parties about the meetings.

Information from surveys identify and help set priorities about needed services. Focus groups are scheduled to allow interested parties to discuss service needs and gaps and to identify the best resources for addressing specific needs. The focus group continues the discussion until consensus is reached and each need has been linked to a particular provider which has been approved by the group. Under the guidance of the San Diego Health Department AIDS Coordination Office, individuals from the community are asked to facilitate the focus groups. County staff take the recommendations that emerge from the focus groups to the Planning Council and to the RWCA Title II Coalition for their input. Typically, recommendations are accepted as they are articulated by the focus groups. The Planning Council decides which of the services are funded under Title I or Title II. County staff develop contracts which are submitted to the Board of Supervisors. The Board of Supervisors grants the final approval. Health department staff develop the contracts, do the final contract negotiations with the selected agencies, and monitor the contracts.

HIV/AIDS Cases and the RWCA Planning Process in the Boston EMA. At the time this study was initiated the Boston EMA was comprised solely of the Boston metropolitan area. Consequently our study sampled only agencies in metropolitan Boston. According to the Boston RWCA 1994 application, until 1994 the Boston EMA comprised a population of 4,171,643 people. According to 1990 U. S. Census data, the metropolitan Boston area is 73 percent non-Latino white, 10 percent Latino, 15 percent African-American, two percent Asian or Pacific Islander, and one percent Native American.

As of December 31, 1993, a total of 3,174 AIDS cases had been reported within the EMA. Cumulatively, 54.2 percent of AIDS cases were reported among non-Latino whites, 9.8 percent among Latinos, 35.3 percent among Blacks, and less than one percent among Asians/Pacific Islanders and Native Americans. About 54.2 percent of the EMA's AIDS cases were reported among gay men, 3.2 percent among IDU gay/bisexual men, and 25.1 percent among IDUs. Sixteen percent of all AIDS cases occurred among women and 1.5 percent among children (Massachusetts Department Public Health, 1994).

According to the 1994 Boston EMA RWCA application, the Planning Council has 31 members, of whom 19 percent are Black/African American, 13 percent are Latino, three percent are Asian/Pacific Islander, and 37.5 percent are individuals who self-identify as living with HIV. The planning process includes a needs assessment conducted by the Public Health AIDS Program in the Boston Department of Health and Hospitals. The Resource Allocation Committee, a sub-committee of the Planning Council, oversees the needs assessment, which is largely carried out by the Public Health AIDS Program. The Planning Council provides feedback on the data presented to them. Separate categories of service are identified after the needs assessment process is concluded and the data are analyzed. Mailings and newspaper advertisements let people know of public hearings that are conducted to gather additional data and identify service needs. The Public Health AIDS Program writes a request for proposals (RFP) incorporating the feedback they receive from the various sources and needs assessment. The RFP is made available upon request. A review committee is convened to examine the proposals received. The reviewers, who are often staff from agencies receiving RWCA funds, are selected by the Public Health AIDS Program and approved by the chair of the Planning Council. Public Health AIDS Program develops the contracts after the reviewers select the agencies they recommend for funding.

B. Sampling Plan

The universe from which the sample was drawn in each EMA consisted of all nonprofit health and human services CBOs that met all of the following criteria:

- they had a client population that was at least 51 percent Latino;
- they had a Board of Directors of which at least 50 percent of the members were from minority communities;
- they were identified in the community as a "Latino agency";
- they provided services to people with HIV/AIDS or who were at high risk for HIV/AIDS.

To identify all potentially eligible CBOs, the following steps were taken: 1) a complete list of all COSSMHO member agencies in the area was obtained; and 2) calls were made to local agencies on the list in order to identify agencies not on the COSSMHO membership list. Calls were made to all the potentially eligible agencies in order to ascertain if they met the criteria for participation.

A total of 10 agencies was to be selected in each study site, and, whenever possible, each site's sample of agencies was to be comprised equally of:

- agencies that did not apply for Title I funds in 1992;

- agencies that applied for, but did not receive, Title I funds in 1992; and

- agencies that received Title I funds in 1992.

Agencies that did not receive Title I funds were chosen in an effort to compare the impact of these funds on capacity building and to assess the barriers to applying for and receiving Title I funds.

The study design called for open-ended interviews with 1) two individuals from each of the agencies participating in the study -- the Agency Executive Director and the HIV Services Coordinator (if there was no HIV Services Coordinator, the Direct Services Coordinator was interviewed); 2) the Planning Council Chair; 3) the Title I Administrator; and 4) the HRSA Project Officer for each EMA. In addition, an agency survey questionnaire was sent out for completion by each Agency Executive Director.

C. Procedures

The methods employed in the study are described below. These include the field test of procedures and instruments, selection of agencies and response rates, description of instruments, and approach to data analyses.

Pilot Test. A pilot test was conducted to assess the strengths and limitations of the study design and determine the appropriateness of the instruments and length of the interviews. In consultation with HRSA and the project's Technical Advisory Panel, Dade County in Florida was selected as the pilot test site.

The interview and survey instruments were pilot-tested with one Title I funded agency (Agency Executive Director and Director of Client Services), one non-funded agency (Agency Executive Director), the Planning Council Chair, the Title I Administrator, and the HRSA Project Officer. Interviews lasted between one and two hours. Interviews with CBO representatives were conducted on site; all other interviews were conducted by telephone. The interviewer wrote all answers as they were provided by the respondents and read them back to ensure that they were recorded accurately. Interviews revealed that many of the questions were not pertinent to the experience of non-funded agencies, and the respondents recommended questions that would be more relevant to non-funded CBOs. Many of these suggestions were incorporated into revisions of the final interview protocol.

The research team held a meeting to review the results and feedback from the pilot test. As a result, all the instruments were revised extensively and submitted to the Technical Advisory Panel members for review.

Selection of Agencies and Participation Rates. Through local and national networks of Latino agencies, 21 agencies were identified as potentially eligible for participation in the two EMAs.[1] After closer screening conducted through phone calls to the agencies, the list was narrowed to 17 eligible agencies, of which 14 (82 percent) agreed to participate.

In EMA X, all six eligible agencies agreed to participate (100 percent). Three of these agencies received Title I funds in 1992 while the other three had never applied for Title I funding. No Latinos CBOs were identified that had applied but had not received Title I funds in 1992. After agreeing to participate, a self-administered survey questionnaire was mailed to each of the Agency Executive Directors and extensive follow-up calls were made to ensure return of the completed survey questionnaires. One survey questionnaire was never returned, and some returned survey questionnaires were incomplete. Follow-up calls were largely successful in obtaining the missing information.

The interviewer did not experience any complications in scheduling the appointments in this EMA. Interviews were conducted on site, with the exception of two interviews conducted over the telephone. Interviews conducted with funded CBOs lasted approximately one hour and 15 minutes with the Agency Executive Directors, and about one hour and 45 minutes with the Direct Service Coordinators. Interviews with respondents from non-funded CBOs took approximately 40 minutes to an hour. Interviews with the HRSA Project Officers, the Title I Administrators, and the Planning Council Chairs lasted between 60 and 75 minutes and were conducted by telephone.

In EMA Y, eight of 11 (73 percent) of the eligible agencies agreed to participate. The lower participation rate in EMA Y was the result of a refusal to participate by three agencies that had not applied for funding. Of the eight participating agencies, two had received Title I funds in 1992, one had applied but not received funds, and five had not applied for Title I funds in 1992.

After agreeing to participate, each of the eight participating CBOs received by mail a self-administered survey questionnaire. All but one were returned after four weeks of intensive follow-up. Upon reviewing the returned instruments, follow-up calls were made to obtain missing information. All interviews with agency staff were conducted in person and no major difficulties were encountered in scheduling interviews. One Executive Director was unavailable for interview, but the agency nevertheless provided a completed survey questionnaire. The interviews with the HRSA Project Officer, Planning Council Chair, and Title I Administrator were conducted by telephone. An unanticipated situation arose when a respondent from the Planning Council chose to terminate an interview when the interviewer asked the respondent to focus responses on the HIV epidemic within the Latino community and on its impact on Latinos and Latino CBOs. At the beginning of the interview the respondent expressed discomfort because of lack of an opportunity to review the questions prior to the interview. The interviewer explained that the interview was being conducted in accordance with study protocol guidelines and that no respondents had seen interview questions prior to their interviews. Most interviewees in this EMA wanted reassurance that the interviews would remain confidential and that names, agencies, and responses could not be traced back to any particular individual.

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[1] From this point onward in the report, the findings do not refer to the EMAs or agencies by name in order to protect the confidentiality of respondents and participating agencies.

D. Instruments

Data were gathered through a survey questionnaire and five interview protocols developed for the study. Instruments were developed by the consultants and revised according to the suggestions of the Technical Advisory Committee and results of the pilot test.

A 16-page survey questionnaire was completed by each agency's Executive Director and/or designee and was comprised of closed-ended questions pertaining to: background information about the number and composition of agency staff, clients, board of directors; services offered; overall budget; management systems and infrastructure; and agency needs for assistance in capacity building. Items about HIV focused on: RWCA Title I funds received; types of HIV services offered; services funded by Title I from 1991-1993; HIV-related policies established by the Board of Directors; and the impact of RWCA funding on capacity building in numerous domains (see Appendix A for a copy of the survey questionnaire).

Respondents were asked to discuss the following: 1) agency background and history (Agency Executive Directors only); 2) knowledge of and experience with the Title I application and process in the local area -- including degree of participation, obstacles experienced, technical assistance received, and efforts to include the Latino community; 3) definition of capacity building; 4) agency capacity to provide HIV/AIDS services prior to 1992 (Agency Executive Directors only); 5) current agency capacity to provide HIV/AIDS services (Agency Executive Directors only); 6) impact of Title I funding on agency systems and capacity (for funded agencies only); 7) challenges faced by Latino CBOs in building capacity to provide HIV/AIDS services; 8) type of activities that should be funded by Title I to support capacity building in Latino CBOs; and 9) suggestions for making the Title I planning and allocation process more responsive to the needs of Latino CBOs. The interviewer kept detailed notes on each interviewee's responses on these topics and on other observations made during the interview and agency visits (see Appendix B for copies of the interview protocols).

E. Approach to Data Analysis

Data from the survey questionnaires were coded and analyzed to provide descriptions of the agencies. Quantative data from the interviewer's notes on responses provided in the interviews and field notes were used to identify common themes and unique issues that emerged across sites and between funded and non-funded agencies.

Another point of this analysis was to ascertain inconsistencies and degree of agreement in the information provided and in the perspectives of the various individuals interviewed within each EMA. Thus, the analyses of interviews focused on identifying 1) intra-site differences and discrepancies in responses and information obtained from the respondents; 2) inter-site differences and similarities in responses and information obtained; and 3) differences and similarities in responses from funded and non-funded agencies.

A database for each interview question was prepared so that responses could be compared for the different agencies, sites, and type of respondent, as well as by whether a given agency applied or did not apply for funds. All interviews were reviewed to identify the major factors that affected the application, funding, and procedural experience for agencies.

IV. FINDINGS

This section of the report presents findings based on complete survey questionnaires from each agency and interviews conducted in each EMA. It is organized in seven sub-sections that describe the sample, the agencies, the Planning Council and application process, the need for and challenge of building service capacity, the impact of Title I funds on capacity building activities, recommendations arising from agency interviews for improving use of Title I funds, and a methodology for assessing the impact of Title I funding on capacity building.

Trends and common themes that emerged from the in-depth interviews generally are presented first. These are followed by analysis of the differences and similarities between: 1) EMA X and EMA Y; 2) agencies that applied and agencies that did not apply (or that applied and did not receive funds); and 3) respondents from Latino CBOs vs. the HRSA Project Officers, Planning Council Chairs, and the RWCA Title I Administrators.

A. Sample

Table 1 shows the number and percent of agencies in the sample that completed the survey questionnaire and interviews. A total of 14 agencies participated in the study, representing an 84 percent participation rate of all eligible agencies. Survey questionnaires were completed by 12 agencies (86 percent) and interviews with Agency Executive Directors were conducted with 12 agencies (86 percent). An additional 15 interviews (total = 27 interviews) were conducted with other agency staff and RWCA Title I personnel as noted in Table 1. Of 14 agencies that participated in the study, survey information is missing for two agencies and interview information is missing for two other agencies.

B: Description of Agencies

This section presents background information and includes a brief description of the history and mission of participating agencies as well as information about their scope of services, budgets, clientele, and staff.

Agency History and Mission. The agencies in the study represent a wide range of Latino community agencies. Ten of the 14 (71 percent) began providing services to Latino communities more than 20 years ago and represent well-established organizations. Four agencies (29 percent) were established more recently, from the mid-1980s through 1991. All of the agencies indicate that their mission is to provide services to Latinos in their communities. The descriptions of agency services and mission provided by the persons interviewed (generally two per agency) illustrate the scope of problems facing Latino communities in the study sites. The multi-service agencies tackle a full range of problems (poverty, housing, employment, drug abuse, health, and mental health) and all ages and

Table 1: Sources of Data from Each EMA

	EMA X N	EMA Y N	TOTAL N(%)
Eligible agencies	6	11	17 (100)
Agencies participating	6	8	14 (84)
Survey questionnaires completed	5	7	12 (86)
Interviews:			
Executive Director	6	6	
Services Director*	4	5	
Council Chair	1	1	
Title I Administrator	1	1	
RWCA Project Officer	1	1	
Total Interviews	13	14	12 (86)

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* In most agencies the interview was conducted with the HIV/AIDS Services Coordinator, and, when no such position existed, with the Direct Services Coordinator and/or Substance Abuse Services Coordinator.

groups of the population (women and children, adolescents, men, the elderly). Even agencies identified as health or medical facilities provide a variety of services directed at meeting the everyday needs of the population. Comprehensive approaches to social/economic problems are generally the norm.

Agency Budget, Scope of Services, Staff and Clients. The agencies in the study had very different budget operations. Their 1993 operating budgets ranged from $245,300 to more than $8 million, with a median operating budget of $750,000.

They also differed in the kinds of services they provided. The sample included five multi-service agencies; three health/medical facilities; a treatment center for Latino substance users; three agencies that focused initially on HIV/AIDS advocacy, care services, and prevention/education; one agency that provides housing development; and one agency that provides services for immigrant women.

Table 2 presents the services provided by the 12 agencies that responded to the survey questionnaire. The most common type of medical/health service provided was health promotion. The most common types of psychosocial services provided were case management and social services. In addition, most agencies reported that they provide advocacy and have community outreach programs. Five of the 12 agencies (41.7 percent) stated that they provide direct clinical and/or support services for persons with HIV/AIDS, and nine agencies (75 percent) provide HIV/AIDS prevention and education.

The agencies we studied also differed in the numbers of full-time staff members (ranging from 0 to 250 staff members, median = 25). Nine (75 percent) of the 12 agencies that responded to the survey reported that more than half of their staff are Latino; in six (50 percent) of the agencies, more that three-fourths of the staff are Latino. The staffs' bilingual capacity contributed to the ability of all the agencies to provide bilingual services. In ten agencies (83.3 percent), at least 70 percent of the staff was reported to be bilingual. Together the agencies served 126,555 clients in 1992, with the number of clients served by each agency ranging from 82 to 31,287. This reflects a great diversity in agency resources and scope of services (see Table 3). On average, more than half (X=62.3 percent) of clients served in these agencies are monolingual Spanish speakers with little or no ability to communicate in English..

. The proportion of clients with HIV/AIDS served by the agencies also ranges greatly, from one percent to 44 percent, with a mean of 8.7 percent of all clients diagnosed as HIV positive and/or having AIDS. Table 4 shows that the majority (86.2 percent) of clients with HIV/AIDS served by these agencies are Latino, of which the majority are Puerto Rican (82.2 per cent), male (82.6 percent), and between the ages of 20 and 60 years of age. This reflects the overall epidemiology of HIV/AIDS among Latinos in the United States. A large majority (67.7 percent) of clients with HIV/AIDS served in the agencies are monolingual Spanish speakers.

Table 2: Services Provided by Agencies
(N = 12 Agencies)

Type of Service	Percent (N)
General Services	
Medical/Health:	
Primary Care	25.0 (3)
Family Planning	16.7 (2)
Health Promotion	75.0 (9)
Prenatal Care	25.0 (3)
Psychosocial:	
Case Management	66.7 (8)
Social Services	58.0 (7)
Family Services	33.0 (4)
Geriatric Services	25.0 (3)
Mental Health	41.7 (5)
Substance Abuse Treatment	41.7 (5)
Other:	
Housing Assistance	33.0 (4)
Advocacy	66.7 (8)
Alternative Education	16.7 (2)
Employment and Training	25.0 (3)
Community Outreach	91.7 (11)
Sports and Recreation	25.0 (3)
HIV/AIDS Services	
Direct Care/Support Services	41.7 (5)
Prevention Services	75.0 (9)

Table 3: Profile of Clients Served by Agencies in 1992*
(N = 12 Agencies)

Total Number of Clients (N = 126,555)	
range:	87 - 31,287
median:	3,500
mean	11,497

Percent Spanish Monolingual Clients (1992)	
range:	20% - 100%
median:	60%
mean:	62.3%

Percent Clients with HIV/AIDS (1992)[a]	
range:	1% - 44%
median:	1%
mean:	8.7%

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[a] 75 percent agencies not funded in 1992 could not provide information on clients with HIV/AIDS.

Experience with the RWCA Application and Planning Process. This section describes the agencies' experience in applying for RWCA funds and their knowledge and participation in the Planning Council's planning process.

Application and Receipt of RWCA Title I Funding. Eight of the 14 agencies in the sample had applied for RWCA Title I funds prior to 1994; two other agencies applied in the period just prior to the interviews in early 1994. Four other agencies decided not to apply (their reasons for not applying are discussed below). Table 5 shows the number of agencies in the sample that received Title I funds from 1990-1993, the amount of funds received by Latino agencies, and the total funds received in the EMA.

In 1991, two Latino agencies received funding; this increased to four agencies in 1992 and to five agencies in 1993. The award amount also increased from a mean of $70,000 in 1991 to $82,000 in 1993. In 1991, Latino CBOs received a total of $141,000 or 3.8 percent of the Title I funds in EMA X and EMA Y combined. Over the following two years this figure nearly doubled and, by 1993, the proportion of funds awarded to Latino CBOs represented 7.4 percent of the total Title I funds (See Table 5).

Table 4: Demographic Profile of Clients with HIV/AIDS Served in 1992*
(N = 6,215 Clients)

	Percent
Racial/Ethnic Group	
Black	1.4
White	2.2
Native American	.1
Asian/P.I.	.1
Latino	86.2
Mexican	8.2
Puerto Rican	82.2
Dominican	1.8
Other Latino	7.8
Gender	
Female	17.4
Male	82.6
Age (yrs.)	
0-12	.0
13-19	.1
20-60	99.7
60+	.2
Spanish Monolingual	67.7
Undocumented	9.6
Migrant	1.2

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*Note: 75 percent of agencies not funded in 1992 could not provide information on clients with HIV/AIDS

Table 5: Total Dollar Amount and Percent of Title I Funding Received by Latino Agencies (1991-1993)*

(N = 12 Agencies)

Year	EMA X	EMA Y	TOTAL
1991	$141,000	$0	$141,000
(N=2)	(9.7%)	(0%)	(3.8%)
1992	$316,138	$38,400	$354,500
(N=4)	(11.4%)	(1.4%)	(6.3%)
1993	$462,459	$124,240	$586,600
(N=5)	(12.3%)	(3.0%)	(7.4%)

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* Information on Title I funding provided to the EMAs was provided by HRSA, information on funding received by Latino agencies was obtained through the agency survey questionnaire

Table 6 shows the HIV/AIDS-related services provided by agencies that completed the survey for three periods: the period prior to 1992, during 1992, and during 1993. It also shows whether these services were funded by Title I during these periods. Prior to 1992, agencies were providing a broad spectrum of over 16 different types of HIV/AIDS-related services, the most common of which were case management (33.3 percent), HIV counseling and testing (33.3 percent), early intervention for clients with HIV (25 percent), primary care for people with HIV/AIDS (25 percent), support groups for people with HIV/AIDS (25 percent), and substance abuse treatment (25 percent). Prior to 1992, two of the 14 agencies in the sample (14.3 percent) received Title I funds for three of the 16 services offered by these agencies -- early intervention for clients with HIV, primary care for people with HIV/AIDS, and drug/medication reimbursement.

Two years later, in 1993, there was a slight increase in the number of agencies offering HIV/AIDS-related care services. The greatest growth was in the number of agencies offering support groups for people with HIV/AIDS (25 percent prior to 1992 and 41.7 percent in 1993), case management (33.3 percent prior to 1992 and 50 percent in 1993), and services to families/caretakers of people with HIV/AIDS (8.3 percent prior to 1992 and 25 percent in 1993). Changes between 1991 and 1993 in the number of agencies that provided other services were modest. For example, in 1993, six of 16 services provided in 1992 were provided by one additional agency (i.e., HIV counseling

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Table 6. Percent of Agencies Providing HIV/AIDS Services and Funded by Title I
Percent (N = 12 Agencies)

HIV Services	Prior to 1992		During 1992		During 1993	
	Provided yes/no	Title I Funded	Provided yes/no	Title I Funded	Provided yes/no	Title I Funded
Case management	33.3(4)	0	33.3(4)	8.3(1)	50(6)	25(3)
HIV counseling and testing	33.3(4)	0	33.3(4)	0	41.7(5)	0
Early intervention for clients with HIV	25(3)	16.7(2)	33.3(4)	25(3)	33.3(4)	25(3)
Primary care for people with HIV/AIDS	25(3)	16.7(2)	25(3)	25(3)	25(3)	25(3)
Emergency care services	0	0	0	0	0	0
Clinical Trials	8.3(1)	0	8.3(1)	0	8.3(1)	0
Home health care	0	0	0	0	0	0
Drug/medication reimbursement	16.7(2)	16.7(2)	16.7(2)	16.7(2)	16.7(2)	16.7(2)
Individual psychotherapy for people with HIV/AIDS	16.7(2)	0	16.7(2)	0	16.7(2)	0
Group psychotherapy for people with HIV/AIDS	8.3(1)	0	8.3(1)	0	8.3(1)	0
Support groups for people with HIV/AIDS	25(3)	0	25(3)	0	41.7(5)	0
Nutrition education	16.7(2)	0	16.7(2)	0	25(3)	0
Food Assistance	8.3(1)	0	20(2)	0	18.2(2)	0
Services to families/caretakers of people with HIV/AIDS	8.3(1)	0	16.7(2)	8.3(1)	25(3)	8.3(1)
Housing assistance	16.7(2)	0	25(3)	0	25(3)	8.3(0)
Substance abuse treatment	25(3)	0	16.7(2)	0	25(3)	0
Other (specify)	16.7(2)	0	16.7(2)	0	16.7(2)	0
Other (specify)	16.7(2)	0	16.7(2)	0	16.7(2)	0

and testing, early intervention, primary care, nutrition education, food assistance, and housing assistance).

By 1993, five of the 12 agencies answering the survey were funded by Title I RWCA funds. These funds helped to support six areas of services (case management, early intervention, primary care, drug medication reimbursement, services to families/caretakers, and housing assistance). In comparison, prior to 1992, RWCA Title I funds had supported only three areas of services. The greatest growth occurred in funding for case management (0 percent prior to 1992 to 25 percent in 1993). Numerous other areas of service provided by the agencies remained unfunded by RWCA Title I (e.g., individual and group psychotherapy, support groups, nutrition education, food assistance and substance abuse treatment).

Information obtained in the interviews indicates that, when received, RWCA Title I funds help agencies expand existing services and sometimes enable them to increase the scope of their services. Title I funds assisted agencies in adding staff that provide HIV/AIDS services. For example, in 1992, there was a total of 17 full-time equivalent staff positions for providing HIV/AIDS services; eight of them (47 percent) were funded by RWCA Title I.

Preexisting Conditions in the Two EMAs. The interviews revealed significant differences in the underlying conditions framing the local RWCA process in each city.

EMA X came into the process with three well-established, large, comprehensive health centers primarily serving Latino clients. For the most part, these agencies had provided some HIV/AIDS services before applying for Title I funds. In 1992, these three Latino CBOs applied for Title I funds and received them. The two multi-service community organizations in EMA X, also long-standing and well-established, did not apply, nor did the recently established, small organization whose mission was exclusively service to persons with HIV.

EMA Y, in contrast, had no Latino clinics or health centers in either the funded or non-funded category. Three Latino agencies were funded: one large, well-established, and long-standing multi-service organization with little prior experience in providing health or HIV services, and two smaller, more recently established organizations devoted to health advocacy, networking, and a variety of health policy/promotion activities. Thus, one of the biggest site differences between the two EMAs was the lack of a Latino health care/medical center or clinic in EMA Y as compared to the existence of agencies in EMA X with an exclusively medical/health care focus. Latino medical clinics/centers have a long history in EMA X as opposed to EMA Y, in which Latinos receive health services in community health centers and hospitals that have no or limited representation of Latinos on their staffs and boards. Latino agencies in EMA Y traditionally have provided social services rather than health services.

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C. The Title I Planning Council and Application Process

This section presents findings from interviews on agencies' knowledge of and participation in the RWCA Title I Planning Council process, their experience in the Title I application process, and barriers and obstacles experienced in the planning and application process. Overall findings are presented first; then site differences are discussed.

Knowledge of and Participation in RWCA Title I Planning Council Process. This section of the report describes what was learned through the 27 interviews about the degree of knowledge and the level of participation of Latino community-based organizations in the RWCA planning process. The 14 Latino community agencies participating in this study represent the overwhelming majority (84 percent) of all eligible Latino agencies in the two cities, and, as a result, their experiences with the RWCA planning process are likely to well represent those of the Latino community overall in these communities.

Information from interviews indicate half of the Latino agencies in the study generally could be categorized as very knowledgeable about and involved in the RWCA planning process. The other half had little or no knowledge of or involvement in the RWCA planning process. Agencies with a high level of knowledge of the planning process were those that had frequent contact with key players and tended to be represented on the Planning Council itself. Interviewees from this group were likely to respond to questions about their knowledge and participation with comments like: "Our executive director is on the Planning Council," "The executive director is an active member [of the Planning Council]," and "our HIV Coordinator serves on the Planning Council." These respondents also were able to name many of the "key players" in the RWCA process, including many members of the Planning Council. Agencies with little knowledge of the planning/application process, in contrast, would typically answer, "don't know" or "no," to questions on this subject, or the interviewer would indicate "not applicable" or "not available" to these questions.

These findings on knowledge and participation were equally true in EMA X and EMA Y. The most significant differences were found, therefore, not by site, but by whether the agency applied or did not apply for RWCA funds. In virtually all cases, those agencies that applied for funds were agencies that had a high level of knowledge and access to the process prior to applying. This knowledge and access was primarily from having a staff member (typically the Agency Executive Director) on the Planning Council. Those agencies that did not apply and the agency that was denied funds had limited knowledge of or access to the process.

Despite the similarities in the view of the process displayed by the Latino agency interviewees, differences by site became clearer when the HRSA Project Officers, Title I Administrators, and Planning Council Chairs were interviewed. In general, these individuals described very different pictures of EMA X and EMA Y. In EMA X, all three individuals portrayed a similar picture -- one in which the process involved a needs assessment, consistent and fair procedures, and a substantial amount of Latino community input. This matched the picture provided by the agency respondents. In contrast, the three individuals representing RWCA from EMA Y showed the same diversity of opinion as described by the agencies from EMA Y; their responses varied from "well organized" to "Planning Council is not diverse." Furthermore, in EMA Y, while the agencies were clearly focused on accessing RWCA funds for Latino services and programs, two of the RWCA interviewees tended not to focus on responses that were specific to Latinos and instead discussed issues pertinent to communities of color in general. Finally, because EMA Y experienced numerous changes in RWCA personnel, existing personnel were not familiar with the history of the process and of efforts to involve Latino agencies.

Agency Experience with RWCA Application Process. Based on information obtained in the interviews, the experience of Latino agencies with the Title I application process differed greatly depending upon whether or not they had applied for funding. Their different experiences provide insights into how different Latino community agencies perceive their role vis-a-vis the HIV/AIDS epidemic and the barriers to participation in the RWCA planning and application process.

The reasons Latino agencies gave for applying for Title I funds ranged from the very general -- "the needs of the community," "the needs of the patients," "help Latinos and kids" -- to the very specific, such as "we had an HIV specialty [clinic] and wanted to increase outreach," and "wanted to develop a satellite clinic." Some agencies (particularly in EMA Y) were responding to a gap in services. One, for example, saw a gap in services when another agency in the area had "done a terrible job doing HIV testing." Another felt that "Anglo" agencies failed to provide appropriate or sensitive care.

Those agencies that did not apply for RWCA funds gave a variety of reasons. One reason was that they received little encouragement to apply because they were not perceived (and they themselves did not perceive their agencies) as eligible. The agencies citing this reason for not applying tended to be either very new or agencies with little experience providing HIV/AIDS services. They noted -- and the RWCA Title I personnel and HRSA Project Officers interviewed agreed with their perception -- that HIV/AIDS was not part of their mission and that since they were "not a health-related agency they should not apply." In a few cases, this perception was held even by agencies that provided a small amount of HIV prevention/education, distributed condoms, and provided brochures on the epidemic.

A second reason for not applying was directly connected to the issue of knowledge and participation. As one individual from an agency that did not apply said: "If you're not in the loop and are new you won't know about the funds." And, in contrast to those that did apply, the interviewer said, "Having a personal relationship with someone connected makes hearing about it possible." While in both cities public announcements were made regarding the availability of funds, for some agencies these were not sufficient mechanisms for obtaining information. Rather, personal relationships were perceived as critical for accessing availability of funds.

Third, other agencies, especially those with a very narrow focus, did not apply because of problems related to a lack of infrastructure, as well as to the small size and struggling condition of some Latino agencies. Finally, in one case, an agency did not apply because of competition for funds; one agency representative said that another organization served "as their fiscal agent and they were requested not to apply for the same funds that organization did."

The process itself was perceived very differently depending on whether a CBO applied, applied and was not funded, or didn't apply at all. Some agencies, especially in EMA X, perceived the process as going very smoothly: "It was positive," there was "consensus," "it was good." On the other hand, it was described as a "terrible" process for other agencies, a process that alienates prospective applicants. One agency that did receive funds explained that the process "was good because our agency is well known, part of the process." For other, newer agencies the experience was not so smooth. One such agency noted that "having to hire someone to write the grant and the grant writing process itself was a taxing experience." Others expressed the need for technical assistance (e.g., grant writing training and direct assistance finding grant writers, and advice during the process) in the application process as crucial for increasing the ability of small or new Latino agencies to take advantage of capacity building measures. The process of pulling together a grant application was difficult for some of the agencies due to the complexity of the application, the short turnaround time, and the existing work load of agency staff. Comments indicating some of the difficulties included: "It (requirements and short time frame) excludes agencies that have not written similar proposals before," it "requires staff to write proposals and be taken away from regular jobs," and "we had to hire someone to write the grant. The process taxed the agency. It would have been impossible for a new agency with less experience writing grants."

Barriers and Obstacles in RWCA Title I Process and Application. Certain problems and barriers were identified that dramatically hindered the ability of agencies to access the RWCA process. Many barriers and obstacles to participation noted below have been noted by others in different areas throughout the country (HRSA, 1991; National Commission on AIDS, 1992; National Minority Congress on AIDS, 1994). Where these problems and barriers existed, they directly affected whether agencies heard about RWCA funds, had access to the application and funding process, felt excluded or included in decision-making, and were successful in increasing their capacity to address HIV/AIDS in their communities.

These problems and barriers centered around issues of 1) representation; 2) commitment of RWCA to address the issue of capacity building for Latino agencies; 3) procedures; and 4) control of process.

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Representation. The lack of representation at multiple levels of the process was identified as a problem area by about half of the interviewees. When Latinos were not adequately represented on the Planning Council, Latino agencies did not feel that their needs were addressed or that they got the funds they required. Some interviewees felt that the Planning Council was a closed group. A typical comment from those who felt that lack of representation was a barrier was as follows: "Meetings are hostile, not welcoming; they use acronyms, all English; it's very white." Another feeling expressed was that "we are not addressing Latino and African American needs." A sense that women and children, especially of color, were not given sufficient priority also was expressed.

Having someone from your agency sit on the Planning Council seemed to be key in hearing about RWCA funds and in getting funded. Virtually all the agencies that received funding had someone on the Planning Council. Many agencies complained that those with no "track record" suffered by not hearing about the funds, by failing to understand non-health agencies could apply, and by not knowing how to proceed with an application. They stated that the application process seemed to favor established agencies with a track record in health, no problems with cash flow, the ability to hire a consultant/grant writer, and someone on the Planning Council. For example, one individual indicated that the Planning Council "tenía principios que parecían un mantra [had guidelines that seemed like a mantra]: large before small, old before new." Another said that "the Council picks agencies it knows, not new agencies." These two comments did not come, as one might expect, from agencies that were denied funds but from individuals whose agencies had representatives on the Planning Councils in their respective cities and who received funding.

Commitment to Capacity Building. Problems seemed to arise here in situations where there was inadequate community/agency input into the planning process. When decisions were made without this input, funding seemed to be restricted to paying staff salaries, and there was insufficient recognition of the need to support staff development, infrastructure, and ancillary services such as transportation, housing, and child care. The lack of funds for overhead in some cases meant that agencies had to promise more than they could fulfill.

Another problem is the partial funding of programs -- funding only one-third to one-half of what an agency requests. While agencies recognize that funds are limited, partial funding posed enormous difficulties for them as they tried to do a job, once again, with inadequate resources. The consequences, as one individual explained, are that agencies commit to more than they can do, staff get burned out, and, as a result, the service provided is only a "bandaid." In addition, this partial funding creates false expectations and discouragement instead of increased capacity and community control. For one agency that applied but was not funded, and even for a significant number that were, the lack of funding for infrastructure support (e.g., funding for overhead costs) was a major barrier to capacity building.

Procedures. While many agencies found the application and funding procedures relatively easy and responsive to the community, this seemed to be generally true where the overall environment of the RWCA process was geared toward inclusiveness, openness, and commitment to building Latino capacity to deal with HIV/AIDS. Where the environment was more closed, the procedures were seen as difficult or, as one interviewee said, "not user friendly."

Some procedural problems involved technical assistance. The need for technical assistance at the application stage was identified by almost all agencies but the largest, oldest, and most experienced in grant writing. Other procedural problems involved the inconsistent application of procedures which left agencies unsure whether rules were applied fairly, whether funding decisions reflected community input, and whether expectations imposed on the agencies were inflexible and arbitrary. In addition, many agencies complained about the short turnaround time for writing the proposal, rigid deadlines, lack of consistent record keeping on the part of the RWCA office (which necessitated re-submission of reports and data), and late reimbursement for invoices. A major problem for several agencies was the fact that services had to start upon receipt of the award letter even though the contract would not be signed for several months; if the agency did not have other funds to use during the interim, they had to return funds because of "late startup date," posing great difficulties. Interviewees noted that frequent cancellations and rescheduling of meetings during the planning and application process (primarily in EMA Y) conveyed the appearance, at least, of inconsistency and arbitrariness.

Community Input into Process. Some of those interviewed noted that there was a drive to include a diverse and representative group of Latino individuals, community groups, and consumers in the RWCA planning and funding process. When these efforts were made and community input was achieved, they expressed satisfaction with the process. Focus groups, flyers, open meetings, personal invitations, and consensus-building all seemed to be techniques that facilitated community input and a sense of power if not a sense of community control.

On the other hand, other interviewees expressed great dissatisfaction with what they perceived to be a lack of community input in the process. They described a situation in which the Planning Council seemed to "have an unspoken agreement" about who would get funded and only held community meetings "to show that the Council is politically correct." "Power is the name of the game," said one interviewee. "The agencies that initially took over are holding tight to the power. They get the funds and throw some small funds to other agencies," the interviewee continued. Whether or not such complaints are "true" is less important than the apparent inability of the RWCA group to satisfactorily communicate and successfully implement a striving for inclusion and community decision-making. Numerous interviews also raised the concern that RWCA funds could not be used to serve undocumented Latinos -- a prohibition described by many as antithetical to the goal of curbing the spread of HIV. Since at the federal level RWCA does not have specific requirements regarding the legal status of clients, it is not clear why community agencies believe that there are prohibitions against serving undocumented individuals with HIV/AIDS. These comments indicate the need to clarify this issue at the local level.

Site Differences in Barriers Experienced. In the above discussion of problems and barriers we have tried to identify the factors that inhibit the building of capacity among Latino agencies in tackling the problem of HIV/AIDS. The factors that posed problems or barriers to that success are described in a way that we hope will be useful in providing tools to communities in a variety of locales. It would be misleading, however, to imply that these barriers were relatively evenly distributed among the agencies whose staffs we interviewed. Such an implication would ignore the socio/political context in which RWCA sites its initiatives. Yet it is precisely this context that needs attention for the successful implementation of Title I for capacity building in Latino CBOs.

In other words, for the most part, the problems and barriers described in the preceding section occurred in one site and not in the other. When contrasted by site, EMA Y struggled with issues of representation, openness, commitment to building Latino capacity, and community input and control of the process. In EMA X there seemed to be considerably more outreach to community groups and consumers, more involvement in the community via focus groups, and greater efforts to involve the community in all phases of decision-making. In EMA Y respondents had the perception that the funding and decision-making process were closed to them and were controlled by a small number of individuals representing certain constituencies. "Planning needs to get away from the universities" and "power of the gay community is asserted and controls the process" were typical comments. Interviewees noted that feeling excluded from the planning process itself was discouraging to Latino agencies, even to those that had received funds.

Of major concern in EMA Y, apparently more than in EMA X, was the decision not to fund indirect costs or overhead costs and the more arbitrary, inflexible administration of procedures. The biggest barrier in EMA X seemed to be the virtual dominance of the medical/health care system, which left non-medical agencies "out in the cold," according to one respondent.

There were considerable inconsistencies in viewpoints among those that participated in the Planning Council in EMA Y about how well the planning process operated. Even those who received funding acknowledged a lack of openness in the process and a predetermined nature to some of the proceedings. Whereas one of the three individuals involved in the planning process in EMA Y claimed that the "Chair of the Planning Council...helps to keep the process open" and indicated that "there is mutual respect," another Planning Council member said: "[It was a] closed group. ...It is not an open process...Meetings are hostile...People get disgusted. It is not a welcoming atmosphere. People talk with acronyms all the time. All in English (no translation)...Tokenism is prevalent. No women with children are brought in. No transportation or child care (is) available."

In general, Latino agencies in EMA X were considerably more satisfied with the application and funding process for Title I than were their counterparts in EMA Y. Non-funded agencies in EMA X also expressed concerns about the lack of information and access by small or non-medical agencies. While the perspectives expressed by the RWCA Title I personnel did not differ significantly from those expressed by the agency representatives interviewed in their respective cities, the perspectives of the three officials in EMA X differed substantially from those in EMA Y. In EMA X, for example, the RWCA Title I personnel supported the agencies concerns by urging attention to special populations (e.g., undocumented immigrants), and increased outreach efforts during the planning and application process. As one said, "the CBOs need technical assistance." In EMA Y, the responses to questions put to RWCA personnel about how to make the process more responsive were very different. In once case, there was an apparent lack of information or involvement and even hostility to the questions being asked; in another, there was considerable commitment and investment in considering what changes would improve the ability of RWCA to increase Latino capacity. For example, one individual had little to say about the subject, another precipitated a premature ending to the interview, and a third had much to say and made many recommendations about how to increase representation and outreach, especially to new agencies.

Our findings suggest that the HRSA Project Officer has a key role to play in ensuring that the local process is inclusive and extends to agencies not currently involved in the Planning Council. It might be advisable, for example, for the HRSA Project Officer to meet on a yearly basis with funded and non-funded agencies in the Latino community in each EMA in order to assess their inclusion and satisfaction with the planning and funding process. HRSA might also develop reward mechanisms through the supplemental Title I grants for EMAs that can document increasing inclusion of Latino CBOs in the Council, in the planning process, and in funded programs. Asking EMAs to report the proportion of Latino agencies that participate in the Planning Council, receive funding, and the total dollar amount going to Latino CBOs also might serve as good mechanisms for monitoring progress toward the goals of inclusion and building capacity to provide HIV/AIDS services in Latino CBOs. In addition, it would be highly useful to ask EMAs to report the ethnic breakdown of clients served in non-Latino agencies in order to assess the degree to which these agencies are meeting the service needs of Latinos with HIV/AIDS. An effective strategy that enhanced inclusion of Latino agencies was the provision of hands-on technical assistance on the RWCA and the application process. HRSA should consider developing a national technical assistance approach that could be implemented at the local or regional level to increase familiarity with the RWCA Title I process and increase the number and types of agencies that apply for funds.

D. Building HIV Services Capacity and Challenges

This section first presents findings from the agency survey and interviews on 1) agencies' needs in overall management systems infrastructure and general capacity building; 2) definitions of capacity building provided by agency staff and Title I staff;

3) ways in which agencies have developed capacity to provide HIV/AIDS services; 4) challenges faced by agencies; 5) the impact of Title I funds on capacity building, 6) challenges posed by receipt of Title I funds; and 7) agency recommendations.

Overall Management Systems Infrastructure and General Capacity building Needs. Before discussing the capacity of agencies to provide HIV/AIDS services, it is important to discuss the overall context of the agencies' management systems and infrastructure as well as the needs they identified in these areas. Data presented in Table 7 show that while most agencies had systems in place for programmatic and administrative evaluation (75 percent) and standardized client records (91.7 percent), only about half had a quality assurance review program (58.3 percent) and utilization review program (50 percent).

When asked in which general areas agencies needed assistance (see Table 8), the following areas of infrastructure development were identified by more than half of the agencies: program planning and design (66.7 percent); program implementation (66.7 percent); program evaluation (75 percent); proposal writing (50 percent); and accessing different funding sources (83.3 percent). A smaller number of agencies also needed assistance in meeting regulatory requirements, accessing third party reimbursement, and implementing automated service delivery/utilization systems. Overall, these responses indicated that Latino CBOs in the study need assistance in developing and strengthening a series of infrastructure systems that affect their overall capacity to provide HIV/AIDS services and to survive in a competitive environment.

Definition. One of the challenges of building capacity via Title I of the RWCA is the great diversity of opinion about what "building capacity" means to Latino agency representatives. How Latino CBOs define capacity building ranges from the very specific (e.g., "hiring a new staff member") to the abstract (e.g., "develop institutional resources," or "to empower") to the complex (e.g., "provide new services, staff development and training, build infrastructure, stabilization of funding, organizational support for HIV positive persons in key positions," or "training, coalition building, fundraising, community and board development"). Many activities were envisioned under these three types of capacity building, including increased funding; the provision of new services, such as medical care for Latino migrant populations, substance abusers, or women and peer education/counseling of persons with HIV/AIDS; "leverage," training to increase availability and skills of experienced staff and/or volunteers; increased ability to assess needs and resources for development of new programs; and "learning" strategies of long- and short-term planning, program evaluation, and design. A few agencies also mentioned board development and the board's ability to impact policy decisions.

No clear cut differences between the two cities emerged with respect to the ways participants defined capacity building, although there was slightly greater sophistication or detail provided in the responses of EMA X. In other words, while interviewees in EMA Y might cite "providing new services," their counterparts in EMA X were more likely to

Table 7: Percent of Agencies with Selected Management Infrastructure Systems
(N = 12 Agencies)

	Funded (N = 5)	Non-Funded (N = 7)	All (N = 12)
		Percent (N)	
Quality Assurance Review	80.0 (4)	37.5 (3)	58.3 (7)
Services Utilization Review	80.0 (4)	62.5 (5)	75.0 (9)
Programmatic and Administrative Evaluation	80.0 (4)	62.5 (5)	75.0 (9)
Standardized Client Record System	100 (5)	87.5 (7)	91.7 (11)

mention additional and more specific types of capacity (e.g., "have room (space), more trained staff, linkages to leverage funds").

Marked differences between the RWCA Title I personnel and the agency representatives also were apparent. The RWCA Title I personnel seemed clearer in their definition of capacity building. One defined it as "working to build infrastructure to compete and adequately provide services" and as "fiscal support, sound board, write and monitor grants, program evaluation, public relations, and staff development." Another focused on the technical assistance that could be provided. A major discrepancy between the RWCA Title I personnel and the funding outcomes emerged in EMA X; whereas the agencies funded all represented Latino medical centers, one of the RWCA Title I personnel indicated that capacity building meant helping "people who come together and want to form an agency, assisting them with their non-profit status; technical assistance to provide services by agencies that had never provided AIDS services before." An example of one such inconsistency is that the EMA with the clearest expectation on the part of the RWCA Title I personnel to develop *new* capacity tended to fund established programs with a "proven track record" in health and HIV service provision.

Table 8: Percent of Agencies Needing Assistance in Various Domains
(N = 12 Agencies)

Assistance Needed in:	Funded (N=5)	Non-Funded (N=7)	Total (N=12)
		Percent (N)	
a. program	40(2)	85.7(6)	66.7(8)
b. program implementation	40(2)	85.7(6)	66.7(8)
c. program evaluation	60(3)	85.7(6)	75.0(9)
d. meeting the needs of Hispanics with HIV/AIDS	40(2)	71.4(5)	58.3(7)
e. reaching Hispanics with HIV/AIDS	40(2)	57.1(4)	50.0(6)
f. recruiting bilingual/bicultural medical staff to provide HIV services	40(2)	57.1(4)	25.0(3)
g. recruiting bilingual/bicultural nursing staff to provide HIV services	40(2)	14.3(1)	25.0(3)
h. recruiting bilingual/bicultural mental health staff to provide HIV services	20(1)	28.6(2)	25.0(3)
i. recruiting bilingual/bicultural counseling staff to provide HIV services	40(2)	42.8(3)	47.7(5)
j. recruiting bilingual/bicultural support staff to provide HIV services	40(2)	42.8(3)	41.7(5)
k. obtaining funds to cover administrative services	100(5)	8.57(6)	91.7(11)
l. proposal writing	40(2)	57.1(4)	50.0(6)
m. meeting various regulatory requirements	40(2)	42.8(3)	41.7(5)
n. accessing different funding sources	80(4)	42.8(3)	83.3(10)
o. identifying and accessing third-party reimbursement	20(1)	28.6(2)	25.0(3)
p. implementing and managing an automated service delivery/ utilization system	40(2)	42.8(3)	41.7(5)

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How Agencies Have Developed Capacity for HIV Services. Nine (75 percent) of the 12 agencies that completed the survey questionnaire provide HIV/AIDS prevention and education programs, and five (42 percent) provide direct medical and/or social services for persons with HIV/AIDS. In discussing their past and current capacity to provide HIV/AIDS direct care services, it is clear that such capacity varied greatly from agency to agency. While some agencies focus exclusively on clients with HIV/AIDS and their families, other agencies provide no specific services for that population. Therefore, the steps needed to build capacity across agencies also differ substantially.

Staff training is an important first step in building capacity to provide services to persons with HIV/AIDS and their families. In the interviews, about half of the agencies noted that they provided (in some cases, relatively brief) staff training on HIV-related issues. However, the scope of training on HIV/AIDS seemed limited in many agencies. Table 9 shows that only a few agencies held staff training on providing services to Latinos with HIV/AIDS for all providers of medical services (8.3 percent) and/or psychosocial services (25 percent).

The scope of HIV/AIDS-related services provided by the agencies also varied widely. Many (including agencies that did not apply for funds) had conducted small-scale prevention and education efforts. Some educational efforts simply involved holding a meeting and handing out condoms and brochures. Three of the agencies had relatively comprehensive HIV/AIDS services that included outreach, individual and group counseling, education programs, and, in one case, a bilingual hotline. A few agencies had tried, with little in the way of funds or support, to "piggyback" HIV/AIDS services onto programs designed for STDs or substance abuse prevention and treatment. For example, one agency described itself as an "alcoholic and drug user center dealing with HIV positive substance abusers without support from anyone." In contrast, the most comprehensive HIV service agencies described themselves as providing medical care to clients with HIV testing, along with outreach, prevention, and a residency program in HIV for physicians. A non-funded agency that had tried to provide HIV services without financial or other resources was forced to close after one year.

The ways in which Latino agencies developed initial capacity to provide HIV services prior to the RWCA varied considerably. Some received grants; others relied on donations and volunteers. Some received state, HRSA, or CDC funds, or utilized funds provided through offices of mental health or local departments of health. Agencies reported that funds from the state for substance abuse treatment "mandated provision of assistance to persons with AIDS." Many agencies developed a variety of networks dedicated to the sharing of information and case management.

The interviews suggest that the biggest differences found in capacity and the ways in which capacity was developed related directly to the larger social context. Funded Latino agencies in EMA X seemed to have an initial capacity substantially higher than agencies in EMA Y and were able to provide testing, counseling, outreach, and case

Table 9: Percent of Agencies Whose Staff Received Training on Providing Services to Latinos with HIV/AIDS
(N = 12 Agencies)

Proportion with Training	*Medical Staff*	*Psychosocial Staff*
	Percent (N)	
All	8.3(1)	25.0(3)
Most	8.3(1)	16.7(2)
A few	8.3(1)	16.7(2)
One	25.0(3)	0
None	25.0(3)	16.7(2)
N/A	25.0(3)*	25.0(3)*

*These agencies reported no staff in these categories.

management within established medical/health centers. RWCA Title I funds, as will be discussed below, allowed them to expand these services. In contrast, Latino agencies in EMA Y had a capacity that was initially considerably lower and seemed to have less access to (or less success in accessing) funds from funding sources.

Some of the agencies that did not apply for RWCA Title I funds continued to provide limited HIV services despite the fact that they did not receive additional funds. These services were primarily in the area of prevention and education (which are not funded by RWCA Title I), although one agency increased its services by hiring a staff member and a consultant to subsequently apply for RWCA Title I funds, while another continued to provide the comprehensive HIV services it had been providing before.

Our findings indicate that there is great diversity of opinion as to what "building capacity" means to Latino agency staff and to RWCA personnel. An effort by HRSA to clarify the meaning of capacity building for HIV/AIDS services among CBOs would help RWCA Title I personnel and community agencies work from a common definition.

Challenges in Building HIV Services Capacity. Latino CBOs face many challenges and barriers in trying to increase their capacity to provide HIV/AIDS services. Some of the challenges most frequently stressed by the RWCA officials who were interviewed include limited infrastructure, limited cash flow, and the need for staff with necessary credentials and experience to compete successfully for the funds. The need for special staff to write grants or manage projects presents particularly difficult problems for small agencies or agencies with a non-medical or narrow focus.

Racism and the relative lack of power within the larger society were additional challenges mentioned by a number of interviewees. In EMA Y, for example, one of the RWCA Title I personnel said "power is the name of the game" and was troubled by the perception that certain gay, white groups had obtained control initially and were holding onto their power. In addition, the whole health care system and process, as one informant said, "is not empowering; it is fragmented." The respondent went on to say that "it is difficult to defund agencies" that traditionally have received the bulk of available funds and, as a result, Latino agencies receive less. The planning process is closed to the needs of Latinos, the respondent stated, particularly to Latino gay men, women, and children. "There are problems of racism, language, and turf," the respondent added.

For many agencies, the lack of integration of HIV/AIDS services into the agency's long-range plan and policies was another barrier to building capacity for HIV/AIDS service provision. Only three of 12 agencies (25 percent) responding to the survey questionnaire reported having a strategic plan for building HIV/AIDS prevention services, and only two agencies (16.7 percent) had such a plan for building HIV/AIDS direct services.

Similarly, as shown in Table 10, most agencies had not adopted policies related to HIV in the workplace or to the provision of HIV prevention, psychosocial services, or medical care services. Without guidance and support from the board of directors, it is difficult for agencies to form a strategic approach toward improving capacity to provide HIV/AIDS services.

The lack of strategic planning and policy development related to HIV/AIDS services may reflect the larger problem of limited training of board members in critical areas for agency development, such as program development, evaluation, management and strategy, advocacy, and fundraising. Table 11 shows that only two agencies of 12 (16.7 percent) stated that all board members had received training in one or more of the above areas. This suggests that an important starting point for capacity building in Latino agencies might be working with boards of directors to build skills in agency development and encourage integrating HIV/AIDS services into the overall agency strategic plan and policies.

Table 10: Agencies with HIV/AIDS Related Policies
(N = 12 Agencies)

Policies adopted by the Board of Directors:	*Funded**	*Non-Funded*	*Total*
		Percent (N)	
a. provision of HIV prevention services	40 (2)	14.3 (1)	25.0 (3)
b. provision of psychosocial HIV services	40 (2)	14.3 (1)	25.0 (3)
c. provision of HIV/AIDS medical care	20 (1)	14.3 (1)	16.7 (2)
d. non-discrimination against persons with HIV/AIDS	60 (3)	57.1 (4)	58.3 (7)
e. non-discrimination against employees with HIV/AIDS	60 (3)	57.1 (4)	58.3 (7)
f. HIV prevention/safety at the workplace	20 (1)	28.6 (2)	25.0 (3)
g. HIV testing confidentiality/anonymity	40 (2)	28.6 (2)	33.3 (4)
h. grievance procedures for client with HIV/AIDS	20 (1)	57.1 (4)	50.0 (6)

* One agency counted here as not having these policies was in the process of developing them.

E. Impact of Title I Funds on Capacity Building

Information on the impact of Title I funds on capacity building in funded agencies was drawn both from the interviews and the survey questionnaires. Table 12 presents data from the survey questionnaire on items that reflect HIV/AIDS-related capacity building in Latino CBOs. In 1992, compared to non-funded agencies, more agencies that were funded by Title I provided HIV prevention services (100 percent vs 57 percent) and HIV/AIDS care services (100 percent vs 0 percent). Funded agencies reported that they served more clients with HIV/AIDS than non-funded agencies (6.198 vs 17). It is important to note that all agencies funded by Title I kept records that

Table 11: Agencies Whose Board Members Received Training*
(N = 12 Agencies)

Proportion with Training	*Percent (N)*
All	16.7(2)
Most	0
Few	33.3(4)
One	33.3(4)
None	16.7(2)

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* Refers to training in program development, evaluation, management, and strategic planning, advocacy or fundraising

enabled them to report on the number and characteristics of persons with HIV/AIDS they had served, while 75 percent of non-funded agencies stated such information was not available. Thus, it is unclear whether the difference noted above between funded and non-funded agencies is a true reflection of the client population served or a result of Title I 's requirement for record keeping. Nonetheless, the inability to document the number of clients with HIV/AIDS may pose a hindrance when previously unfunded agencies seek RWCA Title I funds.

The survey questionnaire data suggest that one of the clearest ways in which Title I funding improved capacity in Latino agencies was through funding for staff. For example, funded agencies had more staff (N=17 FTE) providing HIV/AIDS services than non-funded agencies (N=1 FTE). Furthermore, in 1992, of 17 staff who provided HIV/AIDS services in funded agencies, eight positions (47 percent) were funded through Title I.

Other important differences also emerged in the areas of staff training and policies developed by the Board of Directors. More funded agencies reported that all or most of their staff providing medical (20 percent vs 14 percent) and/or psychosocial (100 vs 0 percent) services had received training on how to provide such services to Latino clients. Furthermore, the Boards of Directors of more funded than non-funded agencies had adopted a short- and/or long-range strategic plan on HIV/AIDS for prevention (100 percent vs 57 percent) and direct/support services (100 percent vs 0 percent).

Table 12: Comparison of Funded and Non-Funded Agencies on Capacity Building for HIV/AIDS Services

(N = 12 Agencies)

	Funded (N = 5)	**Non-Funded (N = 7)**
Agency Characteristics		
Years in Operation (X)	20.2	19.3
1992 Budget (X)	$3,171,400	$1,395,775
1992 Number of All Clients (X)	22,597	5,154
1994 FTE Staff (X)	103.6	39.3
HIV/AIDS Services and Staff		
Provides HIV Prevention (%)	100%	57%
Provides HIV/AIDS Care Services	100%	0%
1992 Clients with HIV/AIDS (N)	6,198	17
1992 HIV/AIDS FTE Staff (N)	3.4	.14
1992 Total HIV/AIDS Staff (N)	17	1
1992 Title I Funded Staff (N)	8	NA
Training and Strategic Planning		
All/Most Staff Trained in Latino-Specific Service Needs (%)		
Medical Providers (%)	20%	14%
Psychosocial Providers (%)	100%	0%
Board Adopted Strategic Plan on		
Prevention (%)	40%	14%
Care/Support Services (%)	40%	0%
All/Most Board Members Received Training (%)	40%	56.6%

In addition to pointing out that funded agencies were able to build their capacity to provide HIV/AIDS services beyond those of non-funded agencies, the questionnaire survey data support information from interviews that indicate that many of these agencies were in the early stages of capacity building. For example, on average, funded agencies had a relatively modest number of staff providing HIV/AIDS care and support services. In addition, many failed to provide training to medical staff about providing services to Latinos. Many had Boards of Directors that had not yet adopted a short- or long-term strategic plan on HIV prevention and/or direct or support services.

Survey data also corroborates the information obtained from interviews that agencies that received no funding tended to be smaller than those that did; this was reflected in overall yearly agency budget ($1,395,775 vs $3,141,410), the yearly average number of overall clients served (5,154 vs 22,597), and the overall number of staff (39.3 vs 103.6). Also, as indicated in interviews, the survey data support the report that many (57 percent) non-funded agencies were providing prevention services, suggesting that they are making efforts to respond to some aspects of the HIV/AIDS needs facing their clients.

Table 13 shows responses from the five funded agencies in which they indicate areas of improvement in services, staff, and administration as a result of receiving RWCA Title I funding. These findings indicate that funding led to increases in the agencies' capacity to meet the needs of Latinos with HIV/AIDS. These additional funds enabled them to serve more Latino clients, expand HIV care services, better assess client needs, and improve program planning, design, and implementation.

Data from the interviews support these reports and help us to understand how Title I funding assisted agencies in building capacity for HIV/AIDS services. Funded agencies reported: increased space available; a greater number of staff members for HIV work; the addition of new programs, such as dental services for clients with HIV; better and more training for staff; more resources for community; and the hiring and development of a staff "committed to community service." Specific improvements in capacity were most noticeable in the areas of staff development and service provision. In agencies where staff had provided services to individuals with HIV before funding, the emphasis was on increased training (e.g., the addition of training on psychosocial issues for people living with HIV/AIDS, issues of infection control, and on development of county-wide training on cultural issues). Services were also expanded for counseling and advocacy. For agencies that had not provided HIV services prior to receiving funds, staff were hired and trained for direct services. New services were provided as a result of Title I funding, including services to migrant workers, primary care for clients with HIV, case management, eligibility counseling, interpreting, and a housing project for women.

On the other hand, responses noted in Table 13 indicate that Title I funds did not assist agencies by supporting key capacity building areas such as funding for

Table 13: Impact of Title I Funds on Agency Capacity
(N = 5 Funded Agencies)

Have Title I Funds Allowed Your Agency to:		**Percent (N)**
Improve Service:		
1.	expand service hours	40(2)
2.	increase the number of clients served	100(5)
3.	increase the number of Latino clients served	80(4)
4.	expand the type of HIV care services offered	100(5)
5.	increased ability to assess client needs	80(4)
6.	improve planning and design	60(3)
7.	improve program implementation	80(4)
8.	improve ability to meet the needs of Latinos with HIV/AIDS	100(5)
9.	improve ability to reach Latinos with HIV/AIDS	60(3)
Increase Staff Capabilities:		
1.	hire more administrative/management staff	0(0)
2.	hire more direct service staff	100(5)
3.	improve the agency's ability to recruit bilingual/bicultural:	
	a. medical staff to provide HIV services	0(0)
	b. mental health staff to provide HIV services	0(0)
	c. nursing staff to provide HIV services	20(1)
	d. counseling staff to provide HIV services	20(1)
	e. support staff to provide HIV services	40(2)
Improve the Agency's Ability to:		
1.	obtain funds to cover administrative costs	0(0)
2.	write proposals	0(0)
3.	conduct program evaluation	0(0)
4.	meet various regulatory requirements	60(3)
5.	access different funding sources	20(1)
6.	identify and accessing third-party reimbursement	20(1)
7.	implement and manage an automated service delivery/utilization system	0(0)

administrative and management staff or functions, improvement of the agency's ability to write proposals, or implementation and management of an automated service delivery/utilization data system. The interviews and other data from the survey questionnaires suggest that RWCA funds did not generally assist agencies in these areas of capacity building since use of the funds was often strictly limited to the provision of direct clinical and support services.

The impact of RWCA Title I funds on board development and leadership development was mixed. There seems to be a general sense that little change occurred in board development, in part because, with funds so limited, no funds were allocated by agency staff for that purpose. In fact, several interviewees responded quite explicitly when asked if there had been any changes in board development or involvement: "No. Teníamos junta de clients antes de Ryan White" (No. We already had a client board before Ryan White), while others simply replied, "no," "no difference," or "don't know." Data from the agency survey (See Table 11) indicate that in most agencies -- whether funded or not -- few board members had received training in areas that are key to board functions (e.g., strategic planning, advocacy, or fundraising).

However, several other agencies reported that their boards had become more aware of HIV/AIDS issues as a result of presentations and other interactions following Title I funding and that this awareness, in turn, led to an increased sensitivity and a sense of Latino "ownership" of the epidemic.

In a similar fashion, comments about leadership around HIV seem to indicate that changes were modest, although the changes that did occur were in a positive direction. For example, many respondents indicated that the Agency Executive Director or other staff had already been on the Planning Council. One, for example, said "there was already leadership; now it has solidified." Another said that the process "has facilitated leadership and allowed the coming together of people to spend time on Ryan White issues." Another explained that participation in the process had helped staff develop leadership skills and helped clients gain access to the system.

Increases in staff and services seemed greater in EMA X than in EMA Y. In part, this may stem from the fact that only two agencies in EMA Y developed new programs following receipt of funds. Of those, one did not supply sufficient information about changes in staffing or services during the interview to determine how their HIV services had changed. In another case, an agency reported a negative change in staff development since funding. In that EMA, where Title I did not pay for staff development, the interviewee felt that there were greater staff expectations without the necessary staff development support.

Other important areas for capacity building seemed largely unaffected by Title I funding. Those unaffected areas included assisting agencies in obtaining funds for administrative costs/staff, leadership development, and board development. Our study findings indicate that Title I funds were used largely to support clinical and support services. While Title I funds can be used for a broad array of activities that enable agencies to build their capacity to provide services, it seems that the local Planning Councils in both EMAs made the decision to fund only activities closely tied to the provision of clinical and support services. While inspired by the great need for increasing direct services to persons with HIV/AIDS, this decision places agencies that have not provided HIV/AIDS services at a disadvantage. Funds were not allocated for the preliminary work (e.g., training of staff and board members, planning) involved in capacity building. More explicit clarification by HRSA on the types of capacity building activities fundable under RWCA could assist local Planning Councils to diversify priorities for funding. In turn, this could encourage agencies with limited experience providing clinical HIV/AIDS services to build capacity in this area.

Negative Effects or Challenges Following Receipt of RWCA Funds. About half of the interviewees from funded agencies indicated that there was a "downside" to Title I funding in terms of the demands and constraints imposed by receipt of these funds. The negative effects that were mentioned included increased paper-work, short turnaround for applying and then complying with procedural regulations, hidden administrative costs, and the need to spend time at extra meetings. While some of these may be unavoidable, given the already strapped nature of many of these agencies, these minor demands actually may be quite burdensome. As discussed earlier, partial funding and the lack of funding for overhead or ancillary services such as transportation and day care within a single program also may create major difficulties for agencies -- even the large ones -- trying to provide a multitude of services on very limited budgets.

These constraints and negative consequences were cited more frequently and appear to have had a greater impact on agencies in EMA Y then in EMA X. This may be the result of the fact that large health centers of the type funded in EMA X often are more stable, have more resources, and have a less strained system of cash flow and administration than the multiservice community organizations that received funding in EMA Y. In EMA X, while paperwork and development of data systems were cited as burdens, the greatest problems seemed to be related to the delivery of services, not to the hidden costs and negative impact on the financial and administrative underpinnings (i.e., potential survival) of the agencies themselves.

For some agencies, especially in one EMA, receipt of RWCA funds posed some problems and limitations that resulted from local restrictions excluding the use of funds for overhead and administrative costs. This problem, particularly acute for smaller and more fiscally constrained organizations, might be alleviated by development of formal guidelines on the funding of administrative costs and overhead.

F. Interview Recommendations for Improving Use of Title I Funds

Agencies should "get help early on in order to *become qualified* to apply." This frequently articulated thought reflects the idea that Title I funds should be allocated for providing information, education, and training and technical assistance *about* the Ryan White Care Act, its funding process, and application process. Agencies felt that technical assistance should start even before they applied for RWCA funds. There needs to be more outreach to agencies (especially to the non-health agencies and to small agencies) and a simplification of the application forms and requirements. Training -- and financial support -- for staff to learn *how* to write successful proposals was considered key. As one non-funded agency suggested: "Estimular a personas en el campo de la salud para servir de `mentors' a estas agencias pequeñas" (Encourage people in the health field to serve as "mentors" to these small agencies).

Some agency interviewees were concerned that an increase in representation and inclusiveness of the types of agencies that could apply and receive funded would require considerably larger overall funds available to RWCA programs. With this concern in mind, one funded health center was of the opinion that "not all agencies should be funded" and that agencies should "keep to their missions." The implication here is that a dilution of effort could occur if funds are spread too thin. For funded agencies, who are also more likely to be represented in the Planning Council, there may be an inherent conflict of interest in diversifying and expanding the agencies that apply for and receive funding. Strategically, it would be important for local Planning Councils to focus on advocating for the full funding of RWCA at the same time that they work toward diversifying and expanding the pool of applicant and funded agencies. Since many of the Latino staff who were interviewed saw a need for increasing the overall amount of RWCA funds, local Planning Councils might consider creating partnerships with Latino CBOs in an attempt to foster stronger partnerships between the Latino community and local Planning Councils.

Increase Latino representation on the Planning Councils. This recommendation, heard again and again, could be fostered by developing guidelines for equitable representation of the Latino community based on their representation among persons with HIV/AIDS, by simplifying parliamentary procedures in the Planning Council meetings and training members on the use of such procedures, by incorporating time at every planning council meeting for community input, and by designing multiple methods for assessing and incorporating the needs of all communities (eg., focus groups, interviews, and working groups).

According to one Executive Director, RWCA should mandate the decision-making committees to include people working in substance abuse, Latinos and Latinas, people who work with children, and people living with AIDS. Another indicated that "the Planning Council has to be examined and adequate representation [assured]." Another, with many suggestions, said the Planning Council should be "mandated to reflect the city," should address the problems and health of undocumented Latinos, and should include "Latino women, closeted gay (Latino) men, and substance abusers."

Local Planning Councils should not be able to disallow funding of indirect and/or overhead costs on grants. Those interviewed felt that it is important that Planning Councils approve expenses for indirect costs and/or overhead costs in order to avoid hampering the participation of smaller agencies unable to bear the cost of operating programs without reimbursement for such costs.

Title I funds should be used for capacity building by providing technical assistance to Latino agencies (especially to smaller or newer agencies and to non-funded agencies) on how to develop and implement clinical and support services for persons with HIV/AIDS. Those interviewed expressed the need for more agencies to learn how to design programs that meet the specific service needs of Latino sub-populations, especially those who are undocumented, women and children, substance abusers, and Latino gay/bisexual men who may not be open about their sexual orientation. Other service areas in which agencies said they need assistance in building capacity include training and maintaining outreach staff; development of coordinated case management and support services (including transportation and child care); provision of services for families of clients with HIV and for clients with HIV who are substance abusers; and provision of housing for persons with HIV/AIDS and their families.

Make Title I funds available for activities that assist agencies in building a strong infrastructure for providing HIV/AIDS clinical and support services. It frequently was noted by those interviewed that newer and smaller Latino CBOs lack sufficient resources for administrative functions and the ability to access the diverse streams of funding that can foster longevity for an organization. The need for supporting agency infrastructure development is evident in responses provided to a question about areas in which agencies need assistance (See Table 8). The most commonly agree upon needs were the need to obtain funds to cover administrative costs (91.7 percent) and the need for accessing different sources of funding (83.3 percent).

Asked to identify areas in which RWCA Title I funds could help Latino CBOs build their capacity to provide HIV/AIDS services, the majority of agencies identified five areas where such funding would be useful (see Table 14): strategic planning (66.7 percent); program design and evaluation (66.7 percent); advocacy (66.7 percent); staff development (75 percent); and board development (75 percent).

These data support information from previously presented survey data (see Section D), in which it was noted that HIV/AIDS prevention and direct services in most agencies are not integrated into the strategic planning process and/or goals, and that board development is a critical step in the development of a plan to increase an agency's capacity to provide HIV/AIDS services.

Table 14: Areas in Which Agencies Need Title I Funds to Build Capacity for HIV/AIDS Services
(N = 12 Agencies)

	Percent (N)
Strategic Planning	66.7 (8)
Program Design and Evaluation	66.7 (8)
Financial Management	33.3 (4)
Advocacy	66.7 (8)
Staff Development	75.0 (9)
Board Development	75.0 (9)

G. Methodology for Assessing Impact of RWCA Title I Funding on Capacity Building

In addition to obtaining information on how RWCA Title I has helped (and could better help) Latino CBOs provide HIV/AIDS services, a second purpose of our study is to develop and pilot-test a methodology that can be used for assessing how RWCA funding has affected the capacity to provide HIV/AIDS services of CBOs in other communities. The methods we developed made use of quantitative and qualitative data obtained through survey questionnaires and in person open-ended interviews. First, this section reviews the potential limitations of this approach for assessing the broader impact of RWCA on capacity building in CBOs in communities of color. Second, revisions of the design and methods are suggested for future use in larger studies of the RWCA process and the impact of RWCA funds on capacity building in CBOs in communities of color.

Challenges and Limitations. Three types of challenges and/or limitations of the methodology were found. These dealt with design, interviews, and completeness of information/data obtained.

The original design called for equal representation from agencies that had obtained funding, from those that had applied but not been funded, and from those that had not applied. This approach proved difficult since the number of Latino agencies were limited and we were unable to identify agencies that fit all three categories in each EMA. However, the design might be appropriate for a larger study that could conduct an analysis by the above three categories over a larger number of sites.

Significant effort was required to engage participants in the study, especially to get them to participate in interviews. Because the study depended on the participation of very busy individuals (e.g., Agency Executive Directors, the Local Planning Council Chairs), it was difficult to schedule appointments to complete interviews, and often required multiple attempts. In order to complete the interviews, the interviewer spent about one week in each EMA. This could prove difficult and costly in a larger study. Using other methods, such as telephone interviews, could be considered in an effort to economize; however, this might affect the quality and depth of interviews.

The interviews also presented a challenge because they took place in the highly charged political contexts that surround the Title I planning and funding process. Confidentiality was of concern to many participants, and they varied in their willingness to share information. While this tended to improve over the course of each interview, some interviewees were keenly aware of the difficulty of maintaining anonymity when only limited people were being interviewed. In a study with a larger sample, this would probably be a less central concern. It seems preferable to maintain anonymity by not identifying cities, agencies, or individuals participating in such a study in an effort to protect participants and enhance the candor of their responses.

Another challenge was obtaining completed survey questionnaires from Agency Executive Directors. Some agencies had difficulty in completing the survey questionnaire because they did not have the data requested readily compiled; others did not see it as a priority. This was especially true in agencies that did not apply for or receive RWCA funds and that did not perceive HIV/AIDS services to be relevant to their mission.

Modifications of the Design for Future Studies. The field testing of this methodology revealed the need for modification in several areas. This section highlights two aspects of the study: 1) design and recruitment issues and 2) instruments and data gathering.

The original design called for a comparison of funded agencies, agencies that applied for funds but were not funded, and agencies that did not apply. As mentioned previously, this small study did not allow for such a comparison. However, a study with a larger number of EMAs and a larger number of agencies could accommodate such a comparison. One recommended change to the design of the study is to also interview a sample of the Planning Council Members; this would add the perspective of other individuals who have input into the process. A second recommended change to the design is to use a prospective design to compare over time key outcomes (e.g., services offered, staff training, number of persons with HIV/AIDS served) among funded and nonfunded agencies.

In a larger study, interviewee participation will be critical. To get a high participation rate and a sufficiently large sample size in each agency and individual category, incentives for participation may be helpful. The need for incentives applies particularly to agencies that are not funded or that have not applied for funds. Participation by Agency Executive Directors might be improved by limiting their interviews to an hour.

Several modifications of the data gathering instruments (i.e., agency survey questionnaire and the interview protocols) also are needed. First, the interview protocols for agency staff should be modified to further explore the level of satisfaction with the process and management of RWCA (e.g., aspects of the process that limit, inhibit or facilitate participation). Second, because some agency staff prefer to conduct interviews in Spanish, the instruments should be formally translated into Spanish to ensure a valid and consistent Spanish version of the interview protocols. In our project, questions were translated by the interviewer in preparation for conducting the interviews. Third, a separate interview protocol for agencies that applied but were not funded should be developed. The interview protocol for agencies that did not apply could easily be adapted for this purpose by adding questions on the process of application and technical assistance. Finally, the agency survey questionnaire should be shortened to include only the most useful and needed data (see Appendix VIII for a revised version).

V. SUMMARY AND RECOMMENDATIONS

Our goal was to conduct a pilot study on the impact of RWCA funds on capacity building in Latino CBOs in two EMAs. The impetus for conducting this study was two-fold. The first objective was to gain some insights into the experience of Latino CBOs with the RWCA process and with building capacity for providing services to persons with HIV/AIDS. It was expected that data from this pilot study would enable us to identify recommendations for enhancing the participation of Latino CBOs. The second objective was to pilot-test a methodology that could be used to obtain information about the impact of RWCA on capacity building in other communities. Certainly this is not meant to suggest that non-Latino agencies don't also have an important role in delivering services to Latino clients with HIV/AIDS. The premise of this project, however, is that Latino agencies have a special role in delivering linguistically and culturally appropriate services and in reaching individuals that may not otherwise seek services in mainstream agencies.

A. Summary of Findings

In general, the findings indicate that:

1) RWCA funding is critical in enhancing and expanding the capacity of Latino community-based agencies to provide HIV/AIDS services to an underserved population.

2) Agencies clearly benefited from funding by allowing them to increase the number of clients served, the types of services offered, and by becoming better able to meet the needs of Latinos with HIV/AIDS and their families.

3) The majority of persons with HIV/AIDS served by Latino agencies in our sample spoke little or no English and therefore needed services to be provided by bilingual staff. Through their capacity to provide linguistically and culturally appropriate services to these Spanish speakers, it is apparent that Latino CBOs fill an important, unmet need.

4) Active participation by Latino CBOs in the RWCA Title I Planning Council and the planning process is best achieved through active outreach and technical assistance to these agencies. Active community participation can be ensured through procedures that honor diversity and the contributions of all members of the community.

5) There is a continued need to build HIV/AIDS service provision capacity within Latino CBOs by supporting infrastructure and program development. Where Latino CBOs felt comfortable with the Planning Council process, there appeared to be more active participation in the planning process, greater funding allocations to Latino CBOs, and increased use of existing Latino agencies to provide services to Latinos with HIV/AIDS.

In considering the findings and recommendations of this study, it is important to keep in mind several of its limitations. First, the study was limited to two EMAs, so the findings may not be generalizable to other EMAs. Second, the study included a limited number of individuals involved in the RWCA process (e.g., not all Planning Council members or all non-funded agencies in the EMA were interviewed). Nevertheless, the study had several strengths that enhance the validity of its findings. These include the support of findings with both qualitative and quantitative data, the inclusion of the majority (84 percent) of eligible Latino CBOs in the two EMAs, and the inclusion of informants at all levels of the process (staff from Latino CBOs, Title I Administrators, Planning Council Chairs, and HRSA Project Officers). Finally, the validity of the findings is supported by their congruence with concerns and issues highlighted in other documents and in national fora with broad representation (National Commission on AIDS, 1992; National Minority Congress on AIDS, 1994).

B. Recommendations for Improving RWCA Title I Participation

Recommendation #1: HRSA develop mechanisms and incentives to reward EMAs for successful efforts that increase the number of Latino CBOs on the Planning Council, in the planning process, and among applicants.

EMAs that achieve a high level of participation and successful applications from communities of color, for example, could be provided with funds to provide technical assistance and training to EMAs that have been less successful in this effort. EMA strategies that demonstrate success in the active participation of communities of color could be highlighted in national conferences sponsored by HRSA and in HRSA publications. describing their efforts. Finally, in their application to HRSA, EMAs should be required to conduct a needs assessment of the service and capacity building of CBOS from each major ethnic minority community affected by HIV/AIDS in its service area. This assessment should also include a list of agencies that provide services to the major ethnic minority populations in the local area, identify which of these are funded by RWCA, and present a plan for integrating new agencies in the RWCA process in order to fill gaps in service to the various ethnic communities.

Recommendation #2: HRSA create active outreach efforts that engage non-medical agencies with existing HIV/AIDS education and outreach programs in the Planning Council and planning process and that encourage their submission of proposals that will develop and provide HIV/AIDS services.

This recommendation could be accomplished through various methods including: a) invited informational and relationship-building meetings at the local level sponsored by the HRSA project officer; b) specialized training conferences and technical assistance designed to assist non-medical agencies in developing direct HIV/AIDS clinical and support services; c) developing collaborative capacity building agreements with other federal, state and local agencies that currently fund non-medical agencies for HIV prevention programs or for non-HIV related programs (e.g., other agencies in the Public Health Service including the Centers for Disease Control, Substance Abuse and Mental Health Services Administration, and departments of public health); d) development and dissemination of case studies describing how EMAs have achieved high level participation by ethnic minority CBOs in the Planning Council; and e) development of written materials by HRSA about the RWCA (purpose, funds available, allowable services) for distribution to all affected communities in Title I EMAs.

Recommendation #3: HRSA develop mechanisms for providing Planning Council Chairs, local RWCA Administrators, and RWCA Project Officers with information about the service needs and capacity building needs of agencies in communities of color within their EMAs.

Initiatives to promote this objective could include: a) annual HRSA sponsored trainings for local Planning Council Chairs and Title I Administrators on the service and capacity building needs of CBOs in communities of color and in the capacity building activities allowable under RWCA Title I, and b) technical assistance for all Planning Councils to help them develop a strategic plan that identifies specific goals for the participation of CBOs from communities of color. The Planning Council Chairs would be required to report annually on progress toward this goal at a national meeting. Finally, in their applications to HRSA, EMAs should be required to conduct a needs assessment of the services and capacity building needs of each major ethnic minority population affected by HIV/AIDS in its service area. This assessment should also include a list of agencies that provide services to the major ethnic minority populations in the local area, identifying which of these are funded by RWCA, and presenting a plan for integrating new agencies in the RWCA process in order to fill gaps in services to the various ethnic communities.

C. Recommendations for Funding Capacity Building Activities

Findings from the study indicate that great discrepancies exist among HRSA Project Officers, Title I Administrators, Planning Council Chairs, and staff from community agencies in their understanding of the meaning of capacity building within the scope of RWCA. A clear understanding of the importance of capacity building and the perception that capacity building activities are appropriate under RWCA are associated with decisions at the local level to fund Latino community-based organizations to carry out such activities.

Recommendation #4: HRSA develop and communicate clear guidelines for HRSA Project Officers, Title I Administrators, and Planning Councils on the kinds of capacity building activities that can and should be funded under RWCA.

To implement this recommendation, HRSA should consider a) developing a written policy statement on the types of capacity building activities that can be funded under RWCA and the percent of budget that each EMA is permitted to spend on funding these activities. These guidelines could then be distributed annually to RWCA Project Officers, Title I Administrators, Planning Council members, and all local applicants; and b) requiring all EMAs to state in their applications the types of capacity building activities that they funded in minority CBOs in the previous year.

Recommendation #5: HRSA include the following in its list of fundable capacity building activities under RWCA: a) administrative costs; b) training for CBO staff on proposal writing and design, implementation and evaluation of HIV/AIDS service and support programs; and c) board training and development, especially in the integration of HIV/AIDS services in the agency long-term strategic plan.

D. Recommendations for Future Research on the Planning Council Process and the Impact of RWCA on Capacity Building

Our findings indicate that Latino CBOs' knowledge about and involvement in the RWCA process is critical if they are to obtain funding. Once agencies were involved in the RWCA process they were likely to apply for funding. Latino CBOs who applied (N= 6) did very well. In 1992, 83.3 percent of those that applied were funded. However, many Latino CBOs that met the criteria for inclusion in the study did not apply for RWCA funds. Of the 15 agencies that met the criteria as a Latino CBO for this study (only 12 agreed to participate), ten agencies did not apply for funds. Thus, out of all Latino CBOs only a third received RWCA funds.

The Latino CBOs in this study received 7.4 percent of the total RWCA dollars allocated in the two EMAs. It is unclear what proportion of funds allocated to non-Latino agencies were used to serve Latinos. In order to get a more complete picture of the use of resources to serve Latinos with HIV/AIDS, EMAs should be required to report the ethnic breakdown of persons served by all funded agencies. While our study sample does not allow for generalizations to other EMAs, the findings reported here resonate with concerns expressed by representatives of communities of color in other regions (National Commission on AIDS, 1992; National Minority Congress on AIDS, 1994). The findings of this pilot study raise concern and indicate a need to more systematically document and monitor the degree of minority CBO representation in the RWCA process, the factors that negatively and positively affect that process at the local level, and the distribution of RWCA funding across diverse ethnic minority communities.

Recommendation # 6: HRSA continue to gather data on a) the representation of ethnic minority CBOs on RWCA Planning Councils; b) the amount of funds received by CBOs in ethnic minority communities throughout all EMAs; and c) the racial/ethnic profile of clients served through RWCA funds. HRSA should employ these data in order to ascertain the responsiveness of EMAs to the needs of ethnic minority communities. These data should be made available to all EMAs.

Recommendation #7: HRSA conduct a series of regional studies with representative samples of EMAs in each region across all titles of RWCA (Title I, Title II, Title III, and Title IV programs). These studies should further investigate the factors that impede or facilitate participation of ethnic minority CBOs in the planning process and application process throughout all RWCA programs.

APPENDIX A:

Survey Questionnaire

ORGANIZATIONAL SURVEY FOR HIV RELATED CAPACITY BUILDING AND SERVICE DELIVERY PROFILE

NATIONAL COALITION OF HISPANIC HEALTH AND HUMAN SERVICES ORGANIZATIONS
AND
BOSTON UNIVERSITY SCHOOL OF PUBLIC HEALTH

DO NOT WRITE HERE

1. AGENCY I.D. ____________________

2. CITY I.D. ____________________

I. BACKGROUND INFORMATION

1. Name of Agency: ______________________________
____

2. Address: ______________________________
____
____

3. Telephone: ______________ Fax: ______________

4. Executive Director: ______________________________

5. HIV Services Coordinator: ______________________________

6. Contact Person: ______________________________
____

7. What geographic area(s) does this agency serve?
____

8. How many years has this agency been in operation?
____

9. Please provide the overall agency budget for each of the following years:

a. 1992: $____________ b. 1993: $____________

10. Please indicate which of the following non-HIV services are provided by your organization:

[1] primary care	[1] yes [2] no
[2] family planning	[1] yes [2] no
[3] social services	[1] yes [2] no
[4] case management	[1] yes [2] no
[5] family services	[1] yes [2] no
[6] housing assistance	[1] yes [2] no
[7] advocacy	[1] yes [2] no
[8] alternate education	[1] yes [2] no
[9] health promotion	[1] yes [2] no
[10] prenatal	[1] yes [2] no
[11] geriatric services	[1] yes [2] no
[12] mental health services	[1] yes [2] no
[13] substance abuse treatment	[1] yes [2] no
[14] employment and training	[1] yes [2] no
[15] community outreach/organizing	[1] yes [2] no
[16] sports/recreation	[1] yes [2] no
[17] ______________________	[1] yes [2] no
[18] ______________________	[1] yes [2] no
[19] ______________________	[1] yes [2] no

11. Does this agency provide HIV/AIDS prevention services?

[1] yes [2] no

12. Does this agency provide HIV/AIDS care services?

[1] yes [2] no

13. Please indicate whether your agency received Ryan White Title 1 funds for any of the following years:

a. 1990	[1] yes [2] no
b. 1991	[1] yes [2] no
c. 1992	[1] yes [2] no
d. 1993	[1] yes [2] no

II. HIV RELATED SERVICES

1. Please indicate if your agency provides or has provided any of the following services and whether these were funded under Title 1:

a) prior to 1992
b) during 1992 and;
c) during 1993

HIV Services	Prior to 1992		During 1992		During 1993	
	Provided: yes/no?	Title I Funded?	Provided: yes/no?	Title 1 Funded?	Provided: yes/no?	Title I Funded?
Case management						
HIV counseling and testing						
Early intervention for HIV+ clients						
Primary care for people with HIV/AIDS						
Emergency care services						
Clinical trials						
Home health care						
Drug/medication reimbursement						
Individual psychotherapy for people with HIV/AIDS						
Group psychotherapy for people with HIV/AIDS						
Support groups for people with HIV/AIDS						
Nutrition education						
Food assistance						
Transportation						
Services to families /caretakers of people with HIV/AIDS						
Housing assistance						
Substance abuse treatment						
Other (specify):						
Other (specify):						
	(45-63)	(64-82)	(83-101)	(102-120)	(121-139)	(140-158)

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2. For all Title I funded programs combined, please provide the level of funds received for each of the following years:

a. 1990: __________

b. 1991: __________

c. 1992: __________

d. 1993: __________

III. CLIENTS

1. How many clients did your organization serve in 1992? _______

2. What percentage of the 1992 agency clients were primarily Spanish speaking monolingual? ______%

3. What percentage of the 1992 agency clients were people with HIV/AIDS? ______%

3a. Of the people with HIV/AIDS receiving care services in 1992, what percentage were:

a. Black (not Hispanic) ______%

b. White (not Hispanic) ______%

c. Native American ______%

d. Asian/Pacific Islander ______%

4. Of all Hispanic clients with HIV/AIDS in 1992, what percentage were:

a. Mexican American/Chicano ______%

b. Cuban American ______%

c. Puerto Rican ______%

d. Dominican ______%

e. Central American ______%

f. South American ______%

g. Spanish American ______%

h. Other (specify): __________ ______%

5. What percentage of the agency client receiving HIV services in 1992 were primarily Spanish speaking monolingual? _____%

6. Of all Hispanic clients with HIV/AIDS in 1992, what percentage were:

a. female _____% c. undocumented _____%

b. male _____% d. migrant workers _____%

7. Of all Hispanic clients with HIV/AIDS in 1992, what percentage were:

a. age 0-12 _____%
b. age 13-19 _____%
c. age 20-60 _____%
d. over 60 years old _____%

IV. STAFF

1. For 1992, how many full-time equivalent (FTEs) position did this agency have? _____

2. For 1992, what percentage of employees spoke Spanish? _____%

3. For 1992, what percentage of the agency staff were Hispanic? _____%

4. For 1992, how many paid full-time equivalent position did this agency have to provide HIV care services? _____

5. For 1992, how many Title I funded full-time equivalent positions did this agency have? _____

6. Of all Title I positions funded in 1992, what percentage were:

a. Hispanic _____%
b. male _____%
c. female _____%
d. full-time _____%
e. part-time _____%
f. people with HIV/AIDS _____%

g. Hispanic persons with HIV/AIDS _____%

7. What percentage of all Title I funded paid staff can speak Spanish? _____%

8. For all Title I funded positions (FTEs), please provide the total number of Hisp6anic FTEs for each of the following years:

Positions	Year			
	1990	1993	1991	1992
Physician				
Physician Assistant				
Nurse				
Licensed Vocational Nurse				
Psychiatrist				
Licensed Mental Health Provider				
Social Worker				
Case Manager				
HIV Counselor				
Psychologist				
Other (specify)				
Other (specify)				

9. Of all medical providers in your agency (e.g., physicians, nurses, what proportion have received training on providing services to Hispanics with HIV/AIDS?

[1] all [2] most [3] a few [4] one [5] none

10. Of all psychosocial services providers in your agency (e.g. therapists, counselors, case managers), what proportion have received training on providing services to Hispanics with HIV/AIDS?

[1] all [2] most [3] a few [4] one [5] none

11. Please identify those areas of additional training needed by your agency staff in order to address the needs of Hispanics with HIV/AIDS?

____

____

____

____

____

____

V. BOARD OF DIRECTORS

1. How many board members does this agency currently have?

____

2. Of all board members, how many are:

a.

Black (not Hispanic) ______
White (not Hispanic) ______
Native American ______
Asian/Pacific Islander ______
Hispanic/Latino ______

b.

number of males ______
number of females ______

c.

Number of people with HIV/AIDS ______
Number of Hispanic persons with HIV/AIDS ______

3. How many board members are Spanish/English bilingual? ______

4. Has this agency adopted a short and long-range strategic plan on HIV/AIDS:

a. Prevention: [1] yes [2] no
b. Service delivery [1] yes [2] no

If yes, please attach copies of these plans to the questionnaire.

5. Please indicate whether the Board of Directors has adopted policies in any of the following areas:

a. provision of HIV prevention services [1] yes [2] no [3]NA

b. provision of psychosocial HIV services [1] yes [2] no [3]NA

c. provision of medical care to people with HIV/AIDS [1] yes [2] no [3]NA

d. non-discrimination against HIV positive/AIDS affected clients [1] yes [2] no [3]NA

e. non-discrimination against HIV positive/AIDS affected employees [1] yes [2] no [3]NA

f. HIV prevention/safety at the workplace [1] yes [2] no [3]NA

g. HIV testing confidentiality/anonymity [1] yes [2] no [3]NA

h. grievance procedures for client with HIV/AIDS [1] yes [2] no [3]NA

Please attach copies of HIV/AIDS related policies adopted by this agency.

6. Briefly describe all HIV/AIDS related training received by Board members in the areas of program development , evaluation, management and strategic planning, advocacy, and fundraising?

7. Of all board members what proportion have received training on program development, evaluation, management and strategy play, advocacy or fundraising?

[1] all [2] most [3] a few [4] one [5] none

VI. Management Systems and Infrastructure

1. Does your agency have:

a. a quality assurance review program? [1] yes [2] no

b. an utilization review program? [1] yes [2] no

c. an overall programmatic and administrative evaluation program? [1] yes [2] no

d. a standardized client record system? [1] yes [2] no

2. If Title I funds were made available to address your agency's capacity building needs, please rate the following capacity building areas:

	Level of Needs			
	very needed 1	needed 2	some what needed 3	not needed 4
strategic planning				
program design and evaluation				
financial management				
fundraising				
advocacy				
staff development				
board development				
other: specify				

3. Have Title I funds allowed your agency to:

a. expand service hours	[1] yes [2] no
b. increase the number of clients served	[1] yes [2] no
c. increase the number of Hispanic clients served	[1] yes [2] no
d. expand the type of HIV care services offered	[1] yes [2] no
e. increase the number of direct service staff	[1] yes [2] no
f. hire more administrative/management staff	[1] yes [2] no
g. increased your ability to assess client needs	[1] yes [2] no
h. improve program planning and design	[1] yes [2] no
I. improve program implementation	[1] yes [2] no
j. improve program evaluation	[1] yes [2] no
k. improve the agency's ability to meet the needs of Hispanics with HIV/AIDS	[1] yes [2] no
l. improve the agency's ability to reach Hispanics with HIV/AIDS	[1] yes [2] no

m. improve the agency's ability to recruit bilingual/bicultural medical staff to provide HIV services	[1] yes [2] no
n. improve the agency's ability to recruit bilingual/bicultural nursing staff to provide HIV services	[1] yes [2] no
o. improve the agency's ability to recruit bilingual/bicultural mental health staff to provide HIV services	[1] yes [2] no
p. improve the agency's ability to recruit bilingual/bicultural counseling staff to provide HIV services	[1] yes [2] no
q. improve the agency's ability to recruit bilingual/bicultural support staff to provide HIV services	[1] yes [2] no
r. improve the agency's ability to obtain funds to cover administrative costs	[1] yes [2] no
s. improve the agency's capabilities proposal writing	[1] yes [2] no
t. improve the agency's ability to meet various regulatory requirements	[1] yes [2] no
u. improve the agency's ability to access different funding sources	[1] yes [2] no
v. improve the agency's ability to identify and accessing third-party reimbursement	[1] yes [2] no
w. improve the agency's ability to implement and manage an automated service delivery/utilization system	[1] yes [2] no
x. other (specify): ______________________	[1] yes [2] no
y. other (specify): ______________________	[1] yes [2] no
z. other (specify): ______________________	[1] yes [2] no
4. Does your agency have an accounting/financial office?	[1] yes [2] no
5. Does your agency have a computerized accounting/financial system?	[1] yes [2] no
6. Please indicate if your agency requires assistance in any of the following areas:	
a. improve program planning and design	[1] yes [2] no
b. improve program implementation	[1] yes [2] no

c. improve program evaluation	[1] yes [2] no
d. meeting the needs of Hispanic with HIV/AIDS	[1] yes [2] no
e. reaching Hispanic with HIV/AIDS	[1] yes [2] no
f. recruiting bilingual/bicultural medical staff to provide HIV services	[1] yes [2] no
g. recruiting bilingual/bicultural nursing staff to provide HIV services	[1] yes [2] no
h. recruiting bilingual/bicultural mental health staff to provide HIV services	[1] yes [2] no
I. recruiting bilingual/bicultural counseling staff to provide HIV services	[1] yes [2] no
j. recruiting bilingual/bicultural support staff to provide HIV services	[1] yes [2] no
k. obtaining funds to cover administrative costs	[1] yes [2] no
l. proposal writing	[1] yes [2] no
m. meeting various regulatory requirements	[1] yes [2] no
n. accessing different funding sources	[1] yes [2] no
o. identifying and accessing third-party reimbursement	[1] yes [2] no
p. implementing and managing an automated service delivery/utilization system	[1] yes [2] no
q. other (specify): ______________________	[1] yes [2] no
r. other (specify): ______________________	[1] yes [2] no
s. other (specify): ______________________	[1] yes [2] no
t. Other (specify) : ______________________	[1] yes [2] no

VII. BACKGROUND OF RESPONDENTS

Please provide the following information on your background.

1. Sex (circle one) _____Male _____Female

2. Age: _______________

3. Ethnic/Cultural/Racial Background (check one):

   1. [ ] African American/Black
   2. [ ] White/Caucasian
   3. [ ] Hispanic/Latino Group:________________________________
   4. [ ] Asian or Pacific Islander
   5. [ ] Native American (American Indian) or Alaskan Native

6. [ ] Other (Specify): ______________________________)

4. Current Job Type (check one that fits best):

1. [ ] Administration/Management
2. [ ] Supervisor of direct service staff
3. [ ] Provider of direct services
4. [ ] Other (specify: ______________________________)

5. Educational Background (check highest level achieved):

1. [ ] Grade School
2. [ ] High School
3. [ ] Associate Degree
4. [ ] Bachelors Degree
5. [ ] Masters Degree
6. [ ] Doctorate
7. [ ] Other professional degree (specify: ____________________)
8. [ ] Other (specify: ______________________________)
   (law, business)

6. Professional Licenses (check all you possess):

1. [ ] Certified Alcohol or Drug Abuse Counselor
2. [ ] MFCC
3. [ ] LCSW
4. [ ] Nurse/Nurse Practitioner/Physician's Assistant
5. [ ] Psychologist
6. [ ] Physician
7. [ ] Other (Specify: ______________________________)

8. How many years of "professional" experience do you have in working on HIV-related services and problems? ____________________ years

9. How many years have you been working in this agency? ____________ years?

10. How many years have you been working in your current position? ____________ years?

THIS IS THE END OF THE SURVEY

THANK YOU FOR YOUR TIME AND COOPERATION

APPENDIX B:

Interview Protocols

RWCA Impact on Capacity Building in Hispanic CBOs
Interview Questions for
Planning Council Chair, City Director of RWCA, HRSA RWCA Project Officer

Interviewer: ______________________________

Date of Interview: ______________________________

Name of Person Interviewed: ______________________

Position: ___ **Planning Council Chair**

___ **City Director of RWCA**

___ **Other (specify)**

Name of Agency: __________________________

Address of Agency: ____

City: ______________ **State:** ________ **Zip** ______

Telephone: ___________________

Introduction: Read to Respondent

As you may know, the Ryan White CARE Act provides funds for services to individuals infected with HIV. Boston/San Diego became a Title I city in ______. That means that certain federal funds were made available to your city for services for HIV-positive people. These funds were intended to improve HIV services for all affected communities, including Hispanic communities in Boston/San Diego. One of the goals of the Ryan White CARE Act is to improve the capacity of agencies to provide quality services for persons with HIV/AIDS.

The federal agency that funds RWCA, the Health Resources and Services Administration (HRSA) has funded a series of small studies to find out how the RWCA funds have impacted local communities and their agencies. In this study they are interested in finding out how RWCA has affected Hispanic community based organizations. For this reason, we are interviewing executive directors and HIV/AIDS staff from Hispanic CBO's in Boston and San Diego; and other key persons involved in the RWCA planning and funding process in each of these cities. As the ___________________ in Boston/San Diego we have asked you to take part in this study because of the background information and context that you can provide for us.

In this interview I will be asking you questions about several things. First, I will ask you about some general questions about the RWCA planning and funding process in this city. Then, I will ask you about your impressions of the participation of Hispanic COB's and the barriers or challenges to participation in the RWCA planning and funding process. Finally, I will ask you about how RWCA funds might be best targeted to capacity building activities.

The interview is confidential and none of your responses will be connected to your name or other identifying information. None except myself and the other project staff will have access to the answers you provide.

Your answers to this interview and the questionnaire will help HRSA improve the Ryan White Title I.

I. Background

1. I would like to start by asking you to tell me about your role in the RWCA planning process in this region.

    1a. How long have you been involved in the RWCA process in this region?

    1b. Briefly describe your role and your experience in the RWCA process in this city.

2. Please describe the general process that was followed in the RWCA planning process in this region.

    2a. Who were the key players in the RWCA planning process in this region?

    2b. What agencies did they represent?

2c. **What were the initial steps taken to involve members of the community and key agencies?**

2d. **Were these steps successful?**

2e. **What major barriers were faced to participation and collaboration?**

3. **What was the response of the Hispanic community and Hispanic CBO's to the RWCA planning process?**

3a. **Who were the Hispanic CBO's and individuals involved in the planning council?**

3b. **Who were the Hispanic CBO's and individuals involved in the funding decisions?**

3c. Tell me about the degree of their participation and effectiveness in the process.

3d. To what extent did Hispanic CBO's apply for funding?

3e. In your opinion, how did the Hispanic community feel or perceive the level of funding they received?

4. What barriers or challenges do you think Hispanic CBO's face in competing for RWCA funding?

4a. Do these agencies need any specific type of technical assistance to compete successfully?

What?

Was this technical assistance provided?

II. Definition of Capacity Building

1. Can you tell me what capacity building to provide HIV services in community agencies means to you?

2. In this interview I will be asking you about capacity building in CBO's. What I mean by this is increasing the agency's ability to deliver HIV/AIDS services through the development of the following types of things:

   Adapting and improving HIV/AIDS services
   Increasing number of clients served
   Staff development and training
   Improvement of system's infrastructure (e.g., fiscal, management)
   Board development and involvement

3. What challenges or barriers do you think Hispanic CBO's have faced in increasing their capacity to provide HIV/AIDS services?

   3a. Are any of these challenges related to the agency's lack of power in relation to mainstream community? If so, explain.

3b. Are any of these challenges related to limited capacity in agencies? If so explain.

4. What suggestions do you have to make the RWCA process more responsive to the needs of Hispanic CBO's?

4a. How familiar do you think Hispanic CBO's are about what is findable by RWCA in your area?

4b. Were there any efforts to make Hispanic CBO's aware of the funding opportunities?

4c. In providing technical assistance to Hispanic CBO's?

4d. What resources do you think Hispanic CBO's need to be able to apply successfully?

5. **Where would RWCA funding be most useful for capacity building in Hispanic agencies?**

5a. **What type of organizational and structural capacity building activities should be targeted for RWCA funding?**

+ **expansion and or improvement of HIV/AIDS services (e.g., service hours, number of clients, types of services)**

+ **staff development and services skills enhancements (e.g., staff training)**

+ **systems improvements (e.g., fiscal systems, management systems)**

+ **board development (e.g., long range planning, strategic planning on HIV/AIDS, development of board members, fundraising, commitment to HIV/AIDS)**

THANK YOU FOR PARTICIPATING AND GIVING US YOUR TIME AND SHARING YOUR EXPERIENCES.

RWCA Impact on Capacity Building in Hispanic CBOs

Interview Questions for Hispanic Community-Based Agency Executive Directors and HIV Coordinators (or Direct Services Coordinators)

[For Agencies that Applied for Funding]

Interviewer: ______________________________

Date of Interview: ______________________________

Name of Person Interviewed: ______________________________

Position: ___ **Executive Director**

___ **HIV/AIDS Coordinator**

___ **Direct Services Director**

___ **Other (specify)**

Name of Agency: ______________________________

Address of Agency: ______________________________

City: ____________ **State:** ________ **Zip** ______

Telephone: ______________________________

SCREENING CHECK [COMPLETE PRIOR TO VISIT]

1. **Are at least 51% of your agency's clients Hispanics?**

   _____ **Yes**

   _____ **No**

2. **Is your board composition at least 50% minority?**

   _____ **Yes**

   _____ **No**

3. **Is this agency known in the community as a Hispanic agency?**

   _____ **Yes**

   _____ **No**

NOTE: IF ALL ANSWERS TO ABOVE ARE YES, INCLUDE IN THE SAMPLE. IF NOT, SELECT ANOTHER AGENCY FROM THE LIST OF RANDOMLY DRAWN AGENCIES.

Introduction: Read to Respondent

As you may know, the Ryan White CARE Act provides funds for services to individuals infected with HIV. Boston/San Diego became a Title I city in ______. That means that certain federal funds were made available to your city for services for HIV-positive people. These funds were intended to improve HIV services for all affected communities, including Hispanic communities in Boston/San Diego. One of the goals of the Ryan White CARE Act is to improve the capacity of agencies to provide quality services for persons with HIV/AIDS.

The federal agency that funds RWCA, the Health Resources and Services Administration (HRSA) has funded a series of small studies to find out how the RWCA funds have impacted local communities and their agencies. In this study they are interested in finding out how RWCA has affected Hispanic community based organizations. For this reason, we are interviewing executive directors and HIV/AIDS staff from Hispanic CBO's in Boston and San Diego. We are interested in speaking to personnel from agencies who received funding from RWCA as well as those that applied and did not receive funding and those who did not apply for the funds.

Your agency has been selected for this interview because you are a Hispanic CBO and have/have not received RWCA funds. In this interview I will be asking you questions about several things. First, I will ask you about some general background questions about the history and mission of your agency. Then I will ask you questions about your agency's experience with RWCA application and funding process. Third, I will ask you about your agency's capacity to provide HIV/ AIDS services . Finally, I will ask you to reflect on the changes that have taken place in the last three years with regard to your agency's capacity for providing HIV/AIDS services.

You have already completed a self-administered questionnaire. The questionnaire is confidential and none of your responses will be connected to your name or other identifying information. None except myself and the other project staff will have access to the answers you provide.

Your answers to this interview and the questionnaire will help HRSA to improve the Ryan White Title I.

I. Background

I'd like to start the interview with some questions that will help me learn more about your agency.

1. Could you please describe briefly the history of the agency (year founded, original purpose and clientele, major expansions and changes over the years esp. in staff and clients). What would you say is the mission or goals of the agency?

II. Experience with RWCA Application and Process

1. Can you please tell me about the degree to which your agency was active in the RWCA planning council and other RWCA committees and activities?

    1a. Did you or anyone from your agency serve on the planning council? Please describe the level and type of participation.

    1b. Did you or anyone from your agency work with the planning council in any other capacity? How? Please describe this experience.

1c. Are you aware of who the key players in the RWCA planning process in your region?

1d. How much and what kind of contact do you have with them?

2. What knowledge did you have of the RWCA in 1992?

2a. (if they had any knowledge:) What made you decide not to apply?

2b. Did you seek technical assistance from any source?

2c. Did anyone encourage you to apply, discourage you?

3. Do you feel any barriers or obstacles exist to agencies like yours in:

3a. Hearing about RWCA funds? If yes, please describe.

3b. Applying for RWCA funds? If yes, please describe.

III. Definition of Capacity Building

1. Can you tell me what capacity building in community agencies means to you?

2. In this interview I will be asking you about capacity building in your agency. What I mean by this is increasing the agency's ability to deliver HIV/AIDS services through the development of the following types of things:

Adapting and improving HIV/AIDS services
Increasing number of clients served
Staff development and training
Improvement of Systems infrastructure (e.g., fiscal, management,)
Board development and involvement

IV. Initial HIV/AIDS Capacity

Now, let's talk about the work your agency was doing in HIV/AIDS services prior to 1992 (before you received RWCA funding).

1. Could you tell me about your agency's capacity to provide HIV services prior to 1992?

   1a. How did the agency develop the initial capacity to provide HIV services prior to 1992?

V. Current HIV/AIDS Capacity

Now, if I could ask you to think about the work your agency has done in HIV/AIDS services since the beginning of 1992 (or after you received RWCA funding).

1. Could you tell me about your agency's current capacity to provide HIV services?

2. Since the beginning of 1992 has anything impacted your agency's ability to provide HIV/AIDS services? If yes, what?

   How?

VI. Systems Changes since beginning of 1992.

1. What suggestions do you have for making the RWCA process more responsive to the needs of Hispanic CBO's?

1a. How familiar do you think Hispanic CBO's are about what is fundable by RWCA in you area staff development?

1b. What resources do you think Hispanic CBO's need to be able to apply successfully?

2. In what areas would RWCA funding be most useful in order to improve/expand your agency's capacity to provide services?

2a. What types of activities should RWCA fund in order to help your agency to improve/enhance its capacity to provide HIV services?

THANK YOU FOR GIVING ME YOUR TIME AND SHARING YOUR THOUGHTS AND EXPERIENCES.

RWCA Impact on Capacity Building in Hispanic CBOs

Interview Questions for Hispanic Community-Based Agency Executive Directors and HIV Coordinators (or Direct Services Coordinators)

[For Agencies that did NOT Apply for Funding]

Interviewer: ______________________________

Date of Interview: ______________________________

Name of Person Interviewed: ______________________________

Position:

- ___ Executive Director
- ___ HIV/AIDS Coordinator
- ___ Direct Services Director
- ___ Other (specify)

Name of Agency: ______________________________

Address of Agency:____

City: ________________ **State:** ____________ **Zip** ________

Telephone: ______________________

Introduction: Read to Respondent

As you may know, the Ryan White CARE Act provides funds for services to individuals infected with HIV. Boston/San Diego became a Title I city in ______. That means that certain federal funds were made available to your city for services for HIV-positive people. These funds were intended to improve HIV services for all affected communities, including Hispanic communities in Boston/San Diego. One of the goals of the Ryan White CARE Act is to improve the capacity of agencies to provide quality services for persons with HIV/AIDS.

The federal agency that funds RWCA, the Health Resources and Services Administration (HRSA) has funded a series of small studies to find out how the RWCA funds have impacted local communities and their agencies. In this study they are interested in finding out how RWCA has affected Hispanic community based organizations. For this reason, we are interviewing executive directors and HIV/AIDS staff from Hispanic CBO's in Boston and San Diego; and other key persons involved in the RWCA planning and funding process in each of these cities. As the ________________ in Boston/San Diego we have asked you to take part in this study because of the background information and context that you can provide for us.

In this interview I will be asking you questions about several things. First, I will ask you about some general questions about the RWCA planning and funding process in this city. Then, I will ask you about your impressions of the participation of Hispanic COB's and the barriers or challenges to participation in the RWCA planning and funding process. Finally, I will ask you about how RWCA funds might be best targeted to capacity building activities.

The interview is confidential and none of your responses will be connected to your name or other identifying information. None except myself and the other project staff will have access to the answers you provide.

Your answers to this interview and the questionnaire will help HRSA improve the Ryan White Title I.

I. Background

1. **I would like to start by asking you to tell me about your role in the RWCA planning process in this region.**

   1a. **How long have you been involved in the RWCA process in this region?**

   1b. **Briefly describe your role and your experience in the RWCA process in this city.**

2. **Please describe the general process that was followed in the RWCA planning process in this region.**

   2a. **Who were the key players in the RWCA planning process in this region?**

   2b. **What agencies did they represent?**

2c. **What were the initial steps taken to involve members of the community and key agencies?**

2d. **Were these steps successful?**

2e. **What major barriers were faced to participation and collaboration?**

3. **What was the response of the Hispanic community and Hispanic CBO's to the RWCAA planning process?**

3a. **What was theresponsee of the Hispanic community and Hispanic CBO's to theRWCAA funding process?**

3b. **Who were the Hispanic CBO's and individuals involved in the planning council?**

3c. Who were the Hispanic CBO's and individuals involved in the funding decisions?

3d. Tell me about the degree of their participation and effectiveness in the process.

3e. To what extent did Hispanic CBO/s apply for funding?

3f. In your opinion, how did the Hispanic community feel or perceive the level of funding they received?

4. What barriers or challenges do you think Hispanic CBO's face in competing for RWCA funding?

4a. Do these agencies need any specific type of technical assistance to compete successfully?

What?

Was this technical assistance provided?

5. **What challenges or barriers do you think Hispanic CBO's have faced in increasing their capacity to provide HIV/AIDS services?**

    5a. **Are any of these challenges attitudinal? If so, explain.**

    5b. **Are any of these challenges structural (e.g., lack of power in relation to mainstream community). If so, explain.**

    5c. **Are any of these challenges related to limited capacity in agencies? If so, explain.**

6. **What suggestions do you have for how to make the RWCA process more responsive to the needs of Hispanic CBO's?**

6a. **How familiar do you think Hispanic CBO's are about what is findable by RWCA in your area?**

6b. **Were there any efforts to make Hispanic CBO's aware of the funding opportunities?**

6c. **In providing technical assistance to Hispanic CBO's?**

6d. **What resources do you think Hispanic CBO's need to be able to apply successfully?**

7. **Where would RWCA funding be most useful for capacity building in Hispanic agencies?**

7a. **What type of organizational and structural capacity building activities should be targeted for RWCA funding?**

+ expansion and/or improvement of HIV/AIDS services (e.g.., service hours, number of clients, types of services)

*** tell me about how funding of these would be helpful to your agency in improving the capacity to provide HIV/AIDS services.**

b.+ staff development and services/skills enhancements (e.g.., staff training)

*** tell me about how funding of these would be helpful to your agency in improving the capacity to provide HIV/AIDS services.**

c.+ systems improvements (e.g.., fiscal systems, management systems)

*** tell me about how funding of these would be helpful to your agency in improving the capacity to provide HIV/AIDS services.**

d.+ **board development (e.g.., long range planning, strategic planning on HIV/AIDS, development of board members, fundraising, commitment to HIV/AIDS)**

* **tell me about how funding of these would be helpful to your agency in improving the capacity to provide HIV/AIDS services.**

THANK YOU FOR PARTICIPATING AND GIVING US YOUR TIME AND SHARING YOUR EXPERIENCES.

APPENDIX C:

Revised Survey Questionnaire

REVISED ORGANIZATIONAL SURVEY FOR HIV RELATED CAPACITY BUILDING AND SERVICE DELIVERY PROFILE

NATIONAL COALITION OF HISPANIC HEALTH
AND HUMAN SERVICES ORGANIZATIONS
AND
BOSTON UNIVERSITY SCHOOL OF PUBLIC HEALTH

DO NOT WRITE HERE

1. AGENCY I.D. ____________________

2. CITY I.D. ____________________

I. BACKGROUND INFORMATION

1. Name of Agency: ______________________________
____

2. Address: ______________________________
____
____

3. Telephone: ______________ Fax: ______________

4. Executive Director: ______________________________

5. HIV Services Coordinator: ______________________________

6. Contact Person: ______________________________
____

7. What geographic area(s) does this agency serve?

____

8. How many years has this agency been in operation?

____

9. Please provide the overall agency budget for each of the following years:

a. 1992: $____________ b. 1993: $____________

10. Please indicate which of the following non-HIV services are provided by your organization:

[1] primary care	[1] yes	[2] no
[2] family planning	[1] yes	[2] no
[3] social services	[1] yes	[2] no
[4] case management	[1] yes	[2] no
[5] family services	[1] yes	[2] no
[6] housing assistance	[1] yes	[2] no
[7] advocacy	[1] yes	[2] no
[8] alternate education	[1] yes	[2] no
[9] health promotion	[1] yes	[2] no
[10] prenatal	[1] yes	[2] no
[11] geriatric services	[1] yes	[2] no
[12] mental health services	[1] yes	[2] no
[13] substance abuse treatment	[1] yes	[2] no
[14] employment and training	[1] yes	[2] no
[15] community outreach/organizing	[1] yes	[2] no
[16] sports/recreation	[1] yes	[2] no
[17] ____________________	[1] yes	[2] no
[18] ____________________	[1] yes	[2] no
[19] ____________________	[1] yes	[2] no

11. Does this agency provide HIV/AIDS prevention services?

[1] yes [2] no

12. Does this agency provide HIV/AIDS care services?

[1] yes [2] no

13. Please indicate whether your agency received Ryan White Title 1 funds for any of the following years:

a. 1990 [1] yes [2] no
b. 1991 [1] yes [2] no
c. 1992 [1] yes [2] no
d. 1993 [1] yes [2] no

II. HIV RELATED SERVICES

1. Please indicate if your agency provides or has provided any of the following services and whether these were funded under Title 1:

a) prior to 1992
b) during 1992 and;
c) during 1993

HIV Services	Prior to 1992		During 1992		During 1993	
	Provided: yes/no?	Title I Funded?	Provided: yes/no?	Title 1 Funded?	Provided: yes/no?	Title I Funded?
Case management						
HIV counseling and testing						
Early intervention for HIV+ clients						
Primary care for people with HIV/AIDS						
Emergency care services						
Clinical trials						
Home health care						
Drug/medication reimbursement						
Individual psychotherapy for people with HIV/AIDS						
Group psychotherapy for people with HIV/AIDS						
Support groups for people with HIV/AIDS						
Nutrition education						
Food assistance						
Transportation						
Services to families /caretakers of people with HIV/AIDS						
Housing assistance						
Substance abuse treatment						
Other (specify):						
Other (specify):						
	(45-63)	(64-82)	(83-101)	(102-120)	(121-139)	(140-158)

BEST COPY AVAILABLE

2. For all Title I funded programs combined, please provide the level of funds received for each of the following years:

a. 1990: __________

b. 1991: __________

c. 1992: __________

d. 1993: __________

III. CLIENTS

1. How many clients did your organization serve in 1992? _______

2. What percentage of the 1992 agency clients were primarily Spanish speaking monolingual? ______%

3. What percentage of the 1992 agency clients were Hispanic/Latino? _______%

4. What percentage of the 1992 agency clients were people with HIV/AIDS? ______%

4a. Of the people with HIV/AIDS receiving care services in 1992, what percentage were:

a. Hispanic/Latino ______%

b. Black (not Hispanic) ______%

c. White (non Hispanic) ______%

d. Native American ______%

e. Asian/Pacific Islander ______%

5. Of all Hispanic clients with HIV/AIDS in 1992, what percentage were:

a. Mexican American/Chicano ______%

b. Cuban American ______%

c. Puerto Rican ______%

d. Dominican ______%

e. Central American ______%

f. South American ______%

g. Spanish American ______%

h. Other (specify): __________ ______%

6. What percentage of the agency clients receiving HIV services in 1992 were primarily Spanish speaking monolingual? ______%

7. Of all Hispanic clients with HIV/AIDS in 1992, what percentage were:

a. female _____%

b. male _____%

c. undocumented _____%

d. migrant workers _____%

8. Of all Hispanic clients with HIV/AIDS in 1992, what percentage were:

a. age 0-12 ______%

b. age 13-19 ______%

c. age 20-60 ______%

d. over 60 years old ______%

IV. STAFF

1. For 1992, how many full-time equivalent (FTEs) positions did this agency have? ______

2. For 1992, what percentage of employees spoke Spanish? ______%

3. For 1992, what percentage of the agency staff were Hispanic? ______%

4. For 1992, how many paid full-time equivalent positions did this agency have to provide HIV care services? ______

5. For 1992, how many Title I funded full-time equivalent positions did this agency have? ______

6. Of all Title I positions funded in 1992, what percentage were Hispanic? _____%

7. What percentage of all Title I funded paid staff can speak Spanish? _____%

8. For all Title I funded positions please provide the total number of FTEs for each of the following years:

Positions	Year			
	1990	1993	1991	1992
Physician				
Physician Assistant				
Nurse				
Licensed Vocational Nurse				
Psychiatrist				
Licensed Mental Health Provider				
Social Worker				
Case Manager				
HIV Counselor				
Psychologist				
Other (specify)				
Other (specify)				

9. Of all medical providers in your agency (e.g., physicians, nurses), what proportion have received training on providing services to Hispanics with HIV/AIDS?

[1] all [2] most [3] a few [4] one [5] none

10. Of all psychosocial services providers in your agency (e.g. therapists, counselors, case managers), what proportion have received training on providing services to Hispanics with HIV/AIDS?

[1] all [2] most [3] a few [4] one [5] none

11. Please identify those areas of additional training needed by your agency staff in order to address the needs of Hispanics with HIV/AIDS?

____

____

____

____

____

____

V. BOARD OF DIRECTORS

1. How many board members does this agency currently have?

____

2. Of all board members, how many are:

a.

Black (not Hispanic) ______
White (not Hispanic) ______
Native American ______
Asian/Pacific Islander ______
Hispanic/Latino ______

b.

number of males ______
number of females ______

c.

Number of people with HIV/AIDS ______
Number of Hispanic persons with HIV/AIDS ______

3. How many board members are Spanish/English bilingual? ______

4. Has this agency adopted a short and long-range strategic plan on HIV/AIDS:

a. Prevention: [1] yes [2] no
b. Service delivery [1] yes [2] no

If yes, please attach copies of these plans to the questionnaire.

5. Please indicate whether the Board of Directors has adopted policies in any of the following areas:

a. provision of HIV prevention services [1] yes [2] no [3]NA

b. provision of psychosocial HIV services [1] yes [2] no [3]NA

c. provision of medical care to people with HIV/AIDS [1] yes [2] no [3]NA

d. non-discrimination against HIV positive/AIDS affected clients [1] yes [2] no [3]NA

e. non-discrimination against HIV positive/AIDS affected employees [1] yes [2] no [3]NA

f. HIV prevention/safety at the workplace [1] yes [2] no [3]NA

g. HIV testing confidentiality/anonymity [1] yes [2] no [3]NA

h. grievance procedures for client with HIV/AIDS [1] yes [2] no [3]NA

Please attach copies of HIV/AIDS related policies adopted by this agency.

6. Briefly describe all HIV/AIDS related training received by Board members in the areas of program development , evaluation, management and strategic planning, advocacy, and fundraising?

7. Of all board members what proportion have received training on program development, evaluation, management and strategy play, advocacy or fundraising?

[1] all [2] most [3] a few [4] one [5] none

VI. Management Systems and Infrastructure

1. Does your agency have:

a. a quality assurance review program? [1] yes [2] no

b. an utilization review program? [1] yes [2] no

c. an overall programmatic and administrative evaluation program? [1] yes [2] no

d. a standardized client record system? [1] yes [2] no

2. If Title I funds were made available to address your agency's capacity building needs, please rate the following capacity building areas:

	Level of Needs			
	very needed 1	needed 2	some what needed 3	not needed 4
strategic planning				
program design and evaluation				
financial management				
fundraising				
advocacy				
staff development				
board development				
other: specify				

3. Have Title I funds allowed your agency to:

a. expand service hours [1] yes [2] no

b. increase the number of clients served [1] yes [2] no

c. increase the number of Hispanic clients served [1] yes [2] no

d. expand the type of HIV care services offered [1] yes [2] no

e. increase the number of direct service staff [1] yes [2] no

f. hire more administrative/management staff [1] yes [2] no

g. increased your ability to assess client needs [1] yes [2] no

h. improve program planning and design [1] yes [2] no

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i. improve program implementation [1] yes [2] no

j. improve program evaluation [1] yes [2] no

k. improve the agency's ability to meet the needs of Hispanics with HIV/AIDS [1] yes [2] no

l. improve the agency's ability to reach Hispanics with HIV/AIDS [1] yes [2] no

m. improve the agency's ability to recruit bilingual/bicultural medical nostaff to provide HIV services [1] yes [2] no

n. improve the agency's ability to recruit bilingual/bicultural nursing staff to provide HIV services [1] yes [2] no

o. improve the agency's ability to recruit bilingual/bicultural mental health staff to provide HIV services [1] yes [2] no

p. improve the agency's ability to recruit bilingual/bicultural counseling staff to provide HIV services [1] yes [2] no

q. improve the agency's ability to recruit bilingual/bicultural support staff to provide HIV services [1] yes [2] no

r. improve the agency's ability to obtain funds to cover administrative costs [1] yes [2] no

s. improve the agency's capabilities proposal writing [1] yes [2] no

t. improve the agency's ability to meet various regulatory requirements [1] yes [2] no

u. improve the agency's ability to access different funding sources [1] yes [2] no

v. improve the agency's ability to identify and accessing third-party reimbursement [1] yes [2] no

w. improve the agency's ability to implement and manage an automated service delivery/utilization system [1] yes [2] no

x. other (specify): ______________________ [1] yes [2] no

y. other (specify): ______________________ [1] yes [2] no

z. other (specify): ______________________ [1] yes [2] no

4.	Does your agency have an accounting/financial office?	[1] yes [2] no
5.	Does your agency have a computerized accounting/financial system?	[1] yes [2] no
6.	Please indicate if your agency requires assistance in any of the following areas:	
a.	improve program planning and design	[1] yes [2] no
b.	improve program implementation	[1] yes [2] no
c.	improve program evaluation	[1] yes [2] no
d.	meeting the needs of Hispanic with HIV/AIDS	[1] yes [2] no
e.	reaching Hispanic with HIV/AIDS	[1] yes [2] no
f.	recruiting bilingual/bicultural medical staff to provide HIV services	[1] yes [2] no
g.	recruiting bilingual/bicultural nursing staff to provide HIV services	[1] yes [2] no
h.	recruiting bilingual/bicultural mental health staff to provide HIV services	[1] yes [2] no
i.	recruiting bilingual/bicultural counseling staff to provide HIV services	[1] yes [2] no
j.	recruiting bilingual/bicultural support staff to provide HIV services	[1] yes [2] no
k.	obtaining funds to cover administrative costs	[1] yes [2] no
l.	proposal writing	[1] yes [2] no
m.	meeting various regulatory requirements	[1] yes [2] no
n.	accessing different funding sources	[1] yes [2] no
o.	identifying and accessing third-party reimbursement	[1] yes [2] no
p.	implementing and managing an automated service delivery/utilization system	[1] yes [2] no
q.	other (specify): ____________________	[1] yes [2] no
r.	other (specify): ____________________	[1] yes [2] no
s.	other (specify): ____________________	[1] yes [2] no
t.	Other (specify) : ____________________	[1] yes [2] no

VII. BACKGROUND OF RESPONDENTS

Please provide the following information on your background.

1. Sex (circle one) _____Male
_____Female

2. Age: _______________

3. Ethnic/Cultural/Racial Background (check one):

1. [ ] African American/Black
2. [ ] White/Caucasian
3. [ ] Hispanic/Latino Group:_________________________________
4. [ ] Asian or Pacific Islander
5. [ ] Native American (American Indian) or Alaskan Native
6. [ ] Other (Specify): ______________________________________)

4. Current Job Type (check one that fits best):

1. [ ] Administration/Management
2. [ ] Supervisor of direct service staff
3. [ ] Provider of direct services
4. [ ] Other (specify: ______________________________________)

5. Educational Background (check highest level achieved):

1. [ ] Grade School
2. [ ] High School
3. [ ] Associate Degree
4. [ ] Bachelors Degree
5. [ ] Masters Degree
6. [ ] Doctorate
7. [ ] Other professional degree (specify:_______________________)
8. [ ] Other (specify:_______________________________________)
(law, business)

6. Professional Licenses (check all you possess):

1. [ ] Certified Alcohol or Drug Abuse Counselor
2. [ ] MFCC

3. [ ] LCSW

4. [ ] Nurse/Nurse Practitioner/Physician's Assistant

5. [ ] Psychologist

6. [ ] Physician

7. [ ] Other (Specify: ____)

8. How many years of "professional" experience do you have in working on HIV-related services and problems? ______________________years

9. How many years have you been working in this agency? ___________years?

10. How many years have you been working in your current position? ___________years?

THIS IS THE END OF THE SURVEY

THANK YOU FOR YOUR TIME AND COOPERATION

APPENDIX D:

Research Team

This study was conceived and directed by Gloria Weissman, Deputy Director, Office of Science and Epidemiology in HRSA's Bureau of Health Resources Development. HRSA selected a research team headed by Dr. Hortensia Amaro, from Boston University, and Carlos A. Vega-Matos, M.P.A., from the National Coalition of Hispanic Health and Human Services Organizations (COSSMHO) in Washington, D.C. Representing over 1,000 CBOs and service providers, COSSMHO is the only national Latino organization solely devoted to addressing the health and human services needs of Latinos in the United States and Puerto Rico.

Dr. Amaro is Professor of Social and Behavioral Sciences at Boston University School of Public Health. Dr. Amaro's research has focused on substance use and reproductive health among young girls and women and on HIV/AIDS prevention among Latinos and women. She is a founder of the Latino Health Institute and the Multicultural AIDS Coalition in Boston and for three years served as president of the board of directors of the Latino Health Institute. Dr. Amaro has conducted needs assessments on HIV/AIDS among Latinos with the Latino Health Institute and the Northeast Hispanic AIDS consortium and is the evaluator of the CDC-funded Latina HIV/AIDS Partnership Plan on HIV/AIDS directed by HDI Programs. Dr. Amaro has over 40 publications in scientific journals and books and her contributions to research, community programs and policy have been recognized by national scientific and community organizations.

At the time of the study, Carlos A. Vega-Matos, M.P.A., was director of the Division of AIDS and Chronic Diseases at COSSMHO. Mr. Vega-Matos has extensive experience in conducting HIV/AIDS related needs assessments throughout the Southwest, Massachusetts, and Los Angeles, California. Mr. Vega-Matos was co-founder of both the Latino Health Institute and the Northeast Hispanic AIDS Consortium, and directed COSSMHO's formation of the Southwest Border AIDS Project. He served as director of HIV counseling and testing programs in for the Los Angeles County Department of Public Health.

Milagros Dávila, M.P.H., served as a consultant to the project helping to design the interview protocols and conducting the interviews. Ms. Dávila has extensive national experience in health and HIV/AIDS issues in general, and in women and Latino health issues in particular. She has served as a consultant to the National Commission on AIDS and to other local and national organizations.

The Technical Advisory Committee provided input and suggestions on all aspects of the project. The members were:

Juan Ledesma
Deputy Director
Los Angeles, Gay and Lesbian Community Services Center

Mara Patermaster
Senior Staff Associate
United States Conference of Mayors

José Toro-Alfonso, Ph.D.
Executive Director
Fundación SIDA de Puerto Rico

Roberto Soliz
Chief, Western Services Branch
Acting Chief, Eastern Services Branch
Division of HIV Services
Health Resources and Services Administration

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